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Subject ID

MARKING INSTRUCTIONS

- Use BLACK or BLUE ink.
- Shade circles like this: ●
- Mistakes must be crossed out with an "X".
- Print in CAPITAL LETTERS and avoid contact with the edge of the box. EXAMPLE:

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z
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- Answer every question to the best of your ability.
- It will take approximately 30 minutes to complete the questionnaire.

DoD RCS # DD-HA(SA)2424 (expires 12/31/2013)
Protocol # NHRC.2009.0015

1. What is your current mailing address?

Address Line 1:

Address Line 2

(optional):

City (or FPO/APO):

State/Province/Region

(or AA/AE/AP):

ZIP/Postal Code:

Country:

2. Phone number:

To update your contact information, please contact us by email at
NHRC-VaccineRegistry@med.navy.mil or by phone at 619-553-9255.

3. What is today's date?

M	M			D	D			Y	Y	Y	Y
<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

4. What is your sex?

 Male Female

5. What is your date of birth?

M	M			D	D			Y	Y	Y	Y
<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	1	9	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

6. What are the last four digits of your Social Security number?

7. What is your Rank/Grade? (For example: E-01, W-05, O-10, etc.)

 -

8. What is your branch of service?

- Army Air Force
 Navy Coast Guard
 Marine Corps

9. What is your current military status?

- Regular Active Duty
 Active Reserve/Guard
 Reserve/Guard (not active)
 Separated

10. What is your **current** marital status?
(Choose the single best answer)

- Single, never married
- Separated (no longer living as a married couple)
- Married (not separated)
- Divorced
- Widowed

11. What is the **highest level** of education that you have **completed**? (Choose the single best answer)

- Less than high school completion/diploma
- High school degree/GED/or equivalent
- Some college, no degree
- Associate's degree
- Bachelor's degree
- Master's, doctorate, or professional degree

12. Are you Hispanic/Latino?

- Yes, Hispanic/Latino
- No, not Hispanic/Latino

13. What is your race? (Mark one or more races to indicate what race you consider yourself to be.)

- American Indian/Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

14. What date did you receive your most recent smallpox vaccination?

M	M			/	D	D			/	Y	Y	Y	Y
										2	0		

15. What is the facility name/location where you received your most recent smallpox vaccination?

16. Did you complete a pre-vaccination screening form before you received your most recent smallpox vaccination?

- No Yes Uncertain

17. On the day you received your most recent smallpox vaccine, did you receive any other vaccinations?

- No Yes

18. Between the **30 days before** and the **30 days after** you received your most recent smallpox vaccine, did you receive any other vaccinations?

- No Yes

If you marked "NO," to BOTH questions 17 and 18 skip to question 20.
If you marked "YES" to EITHER question, please proceed to question 19.

19. Please list all of the other vaccinations you received on the day you received your most recent smallpox vaccine, or in the **30 days before** or the **30 days after** you received your most recent smallpox vaccination.

	M	M	/	Y	Y	Y	Y		M	M	/	Y	Y	Y	Y	
a.	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		f.	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b.	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		g.	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c.	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		h.	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d.	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		i.	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
e.	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		j.	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

20. How many anthrax vaccine doses did you receive on or before the date of your last smallpox vaccination?

<input type="text"/>	<input type="text"/>
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For questions 21 and 22, a "close contact" means a person who you live with. It also means a person you have close physical contact with such as a sex partner or someone you share a bed with. Friends or people you work with are not "close contacts".

21. Prior to your most recent smallpox vaccination, did you **OR** a close contact have any of the following health conditions?

- | | | | |
|---|--------------------------|-------------------------------|------------------------------------|
| a. Currently have cancer, or were treated for cancer in the 3 months prior to receiving the smallpox vaccine? | <input type="radio"/> No | <input type="radio"/> Yes, me | <input type="radio"/> Yes, contact |
| b. Ever had an organ or bone marrow transplant? | <input type="radio"/> No | <input type="radio"/> Yes, me | <input type="radio"/> Yes, contact |
| c. Have a disease that affects the immune system like HIV/AIDS, lymphoma, leukemia, or a primary immune deficiency disorder? | <input type="radio"/> No | <input type="radio"/> Yes, me | <input type="radio"/> Yes, contact |
| d. Have systemic lupus erythematosus or another severe autoimmune disease that may weaken the immune system? | <input type="radio"/> No | <input type="radio"/> Yes, me | <input type="radio"/> Yes, contact |
| e. Have Darier's disease, a skin disease that usually begins in childhood? | <input type="radio"/> No | <input type="radio"/> Yes, me | <input type="radio"/> Yes, contact |
| f. Have many breaks in the skin (such as those caused by bad burns, impetigo, psoriasis, pityriasis rosea, herpes, very bad acne, poison ivy, poison oak, chickenpox, shingles, or other rashes such as bad diaper rash and rashes caused by prescription medicines)? | <input type="radio"/> No | <input type="radio"/> Yes, me | <input type="radio"/> Yes, contact |
| g. Have ever been told by a health care provider you or a close contact has atopic dermatitis (often called "eczema"), even if the condition is mild, not currently active, or only had it as a baby or child? | <input type="radio"/> No | <input type="radio"/> Yes, me | <input type="radio"/> Yes, contact |

22. Prior to your most recent smallpox vaccination, did you **OR** a close contact take any of the following treatments or medications?

- | | | | |
|---|--------------------------|-------------------------------|------------------------------------|
| a. Took steroids such as prednisone or related medicine either by mouth or intravenously for 2 weeks or longer in the month before you received the smallpox vaccine? | <input type="radio"/> No | <input type="radio"/> Yes, me | <input type="radio"/> Yes, contact |
| b. Took medicines in the 3 months prior to receiving the smallpox vaccine that affect the immune system (such as methotrexate, cyclophosphamide, cyclosporine)? | <input type="radio"/> No | <input type="radio"/> Yes, me | <input type="radio"/> Yes, contact |
| c. Had radiation therapy in the 3 months prior to receiving the smallpox vaccine? | <input type="radio"/> No | <input type="radio"/> Yes, me | <input type="radio"/> Yes, contact |

23. Prior to your most recent smallpox vaccination did you **EVER** have any of the following heart conditions?

- | | | |
|---|--------------------------|---------------------------|
| a. A previous heart attack, angina, or other coronary artery disease (disease in the vessels that bring blood to the heart)? | <input type="radio"/> No | <input type="radio"/> Yes |
| b. Cardiomyopathy (heart muscle becomes enlarged and doesn't work as it should)? | <input type="radio"/> No | <input type="radio"/> Yes |
| c. Congestive heart failure? | <input type="radio"/> No | <input type="radio"/> Yes |
| d. Stroke or transient ischemic attack (a "mini-stroke" that produces stroke-like symptoms but no lasting damage)? | <input type="radio"/> No | <input type="radio"/> Yes |
| e. Chest pain or shortness of breath with activity (such as walking up stairs)? | <input type="radio"/> No | <input type="radio"/> Yes |
| f. Chest pain unrelated to physical activity? | <input type="radio"/> No | <input type="radio"/> Yes |
| g. Chest pressure? | <input type="radio"/> No | <input type="radio"/> Yes |
| h. Palpitations/pounding heart unrelated to physical activity (such as walking up stairs)? | <input type="radio"/> No | <input type="radio"/> Yes |
| i. Abnormal ECG (electrocardiogram)? | <input type="radio"/> No | <input type="radio"/> Yes |
| j. Myocarditis and/or pericarditis? | <input type="radio"/> No | <input type="radio"/> Yes |
| k. Have you been told by a doctor that you have high blood pressure? | <input type="radio"/> No | <input type="radio"/> Yes |
| l. Have you been told by a doctor that you have high blood cholesterol? | <input type="radio"/> No | <input type="radio"/> Yes |
| m. Do you have a heart murmur or other heart condition that makes it necessary for you to take antibiotics before getting dental work done? | <input type="radio"/> No | <input type="radio"/> Yes |
| n. Any other heart condition under the care of a doctor? | <input type="radio"/> No | <input type="radio"/> Yes |

→ If "YES", please specify:

24. Family cardiac history:

- | | | | |
|---|--------------------------|---------------------------|------------------------------|
| a. Did your biological grandmother(s), mother, or sister(s) develop heart disease before they were 65 years of age? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unsure |
| b. Did your biological grandfather(s), father, or brother(s) develop heart disease before they were 55 years of age? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unsure |
| c. Do you have a first degree relative (for example, mother, father, sister, or brother) who developed a heart condition before the age of 50? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unsure |
| d. Do you have a family history of myocarditis? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unsure |
| e. Do you have a family history of pericarditis? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unsure |

25. Prior to your most recent smallpox vaccination, did you have a history of any of the following:

a. Headaches	<input type="radio"/> No	<input type="radio"/> Yes
b. Memory loss	<input type="radio"/> No	<input type="radio"/> Yes
c. Psychiatric illness	<input type="radio"/> No	<input type="radio"/> Yes
d. Seizures	<input type="radio"/> No	<input type="radio"/> Yes
e. Dizziness/Fainting spells	<input type="radio"/> No	<input type="radio"/> Yes
f. Numbness or paralysis	<input type="radio"/> No	<input type="radio"/> Yes
g. Shortness of breath	<input type="radio"/> No	<input type="radio"/> Yes
h. Blood clots	<input type="radio"/> No	<input type="radio"/> Yes
i. Asthma (include exercise induced)	<input type="radio"/> No	<input type="radio"/> Yes
j. Eczema	<input type="radio"/> No	<input type="radio"/> Yes
k. Diabetes or high blood sugar	<input type="radio"/> No	<input type="radio"/> Yes
l. Chronic fatigue syndrome	<input type="radio"/> No	<input type="radio"/> Yes
m. HIV	<input type="radio"/> No	<input type="radio"/> Yes
n. Meningitis	<input type="radio"/> No	<input type="radio"/> Yes
o. Encephalitis	<input type="radio"/> No	<input type="radio"/> Yes

26. Have you **EVER** been diagnosed with any of the following infections or illnesses?

If "YES", what is the most recent year that you received this diagnosis?

If "YES", most recent year of diagnosis?

a. Coxsackie Virus (group B)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't know	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b. Enterovirus	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't know	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c. Adenovirus	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't know	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d. Parvovirus B19	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't know	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
e. Human Herpesvirus 6	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't know	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
f. Epstein-Barr virus.....	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't know	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
g. Influenza (flu)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't know	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
h. Lyme disease	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't know	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
i. Other.....	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't know	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
→ If other, please specify:				<input type="text"/>			

27. Have you **EVER** had any of the following surgeries:

If **Yes**, what was the date of the surgery?

a. Angioplasty (percutaneous coronary interventions [PCI], balloon angioplasty, or coronary artery balloon dilation)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="text"/> / <input type="text"/>
				M M / Y Y Y Y
b. Cardiac stent procedure	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="text"/> / <input type="text"/>
				M M / Y Y Y Y
c. Bypass surgery (CABG or "cabbage," coronary artery bypass graft, or open heart surgery)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="text"/> / <input type="text"/>
				M M / Y Y Y Y
d. Minimally invasive heart surgery (including robot assisted heart surgery)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="text"/> / <input type="text"/>
				M M / Y Y Y Y
e. Artificial heart valve surgery (heart valve replacement surgery)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="text"/> / <input type="text"/>
				M M / Y Y Y Y
f. Arterectomy	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="text"/> / <input type="text"/>
				M M / Y Y Y Y
g. Radio frequency ablation (catheter ablation)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="text"/> / <input type="text"/>
				M M / Y Y Y Y
h. Cardiomyoplasty (experimental procedure)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="text"/> / <input type="text"/>
				M M / Y Y Y Y
i. Transmyocardial re-vascularization (TMR)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="text"/> / <input type="text"/>
				M M / Y Y Y Y
j. Pacemaker	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="text"/> / <input type="text"/>
				M M / Y Y Y Y
k. Other	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unknown	<input type="text"/> / <input type="text"/>
				M M / Y Y Y Y

→ If **"YES"**, please specify:

28. Within **6 months** after receiving your most recent smallpox vaccination, did you have any of the following symptoms?

a. Weakness (not related to exercise)	<input type="radio"/> No	<input type="radio"/> Yes
b. Fever	<input type="radio"/> No	<input type="radio"/> Yes
c. Gastrointestinal symptoms	<input type="radio"/> No	<input type="radio"/> Yes
d. Shortness of breath	<input type="radio"/> No	<input type="radio"/> Yes
e. Chest pain	<input type="radio"/> No	<input type="radio"/> Yes

If you did NOT experience chest pain within 6 months after receiving the smallpox vaccine, please skip to question 31 on page 8. If you marked "YES" to question 28e, please proceed to question 29.

29. The following questions relate to the chest pain you experienced within **6 months** after receiving your most recent smallpox vaccination. Did the pain...

a. Increase when you lie on your back?	<input type="radio"/> No	<input type="radio"/> Yes	e. Worsen when leaning forward while sitting?	<input type="radio"/> No	<input type="radio"/> Yes
b. Decrease when you lie on your back?	<input type="radio"/> No	<input type="radio"/> Yes	f. Feel tender when you touch it?	<input type="radio"/> No	<input type="radio"/> Yes
c. Improve when lying on one side?	<input type="radio"/> No	<input type="radio"/> Yes	g. Other? (if YES, please describe)	<input type="radio"/> No	<input type="radio"/> Yes
d. Worsen when lying on one side?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/>		

describe other chest pain

30. The following questions ask how much your **heart condition** affected your life during the **4 weeks** following your myopericarditis diagnosis. After each question, select 0, 1, 2, 3, 4, or 5 to show how much your life was affected. If a question **does not** apply to you, mark the 0 after that question.

Did your **heart condition** prevent you from living as you wanted during the **4 WEEKS** following your myopericarditis diagnosis:

	No	Very Little	Moderately	Very Much		
a. Causing swelling in your ankles or legs?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
b. Making you sit or lie down to rest during the day?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
c. Making your walking about or climbing stairs difficult?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
d. Making your working around the house or yard difficult?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
e. Making your going places away from home difficult?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
f. Making your sleeping well at night difficult?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
g. Making your relating to or doing things with your friends or family difficult?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
h. Making your working to earn a living difficult?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
i. Making your recreational pastimes, sports or hobbies difficult?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
j. Making your sexual activities difficult?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
k. Making you eat less of the foods you like?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
l. Making you short of breath?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
m. Making you tired, fatigued, or low on energy?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
n. Making you stay in a hospital?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
o. Costing you money for medical care?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
p. Giving you side effects from treatments?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
q. Making you feel you are a burden to your family or friends?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
r. Making you feel a loss of self-control in your life?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
s. Making you worry?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
t. Making it difficult for you to concentrate or remember things?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
u. Making you feel depressed?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

31. In the **year prior** to receiving your myopericarditis diagnosis, did you take over the counter or prescription non-steroidal anti-inflammatory drugs (NSAIDs)? NSAIDs include aspirin, ibuprofen, and naproxen, which are frequently used to relieve fever, pain, and/or inflammation. There are several generic and name brand versions of NSAIDs, such as Motrin®, Advil®, Aleve®, and Relafen®.

- No Yes

32. Did you take NSAIDs in the **30 days AFTER** receiving your myopericarditis diagnosis?

- No Yes, weekly Yes, 3-4 times/week Yes, daily

If you marked "NO," to both 31 AND 32, please skip to question 34.
If you marked "YES" to either 31 OR 32, please proceed to question 33.

33. Please list all of the NSAIDs (over the counter and/or prescription) that you have taken beginning the year prior to and the 30 days after your myopericarditis diagnosis.

	Type/name of NSAID	Dose (in mg)	Frequency					Rarely
			More than once a day	Daily	4-6 times a week	2-3 times a week	Weekly	
a.	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b.	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c.	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d.	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

34. Are you allergic to any medications?

- No
 Yes, if yes, please specify:

35. Excluding allergies to medications, do you have any allergies? (for example, latex allergy, hay fever, peanut, etc.)

- No
 Yes, if yes, please specify:

36. Have you ever been diagnosed with an autoimmune disorder (e.g. Graves' disease, rheumatoid arthritis, systemic lupus erythematosus, etc.)?

- No
 Yes, if yes, please specify: **If Yes, date of diagnosis?**
M M / Y Y Y Y

37. In the **year prior** to receiving your myopericarditis diagnosis, were you taking any prescription medications?

No Yes

38. Since receiving your myopericarditis diagnosis, have you taken any prescription medications?

No Yes

If you marked "NO," to both 37 and 38, please skip to question 40.
If you marked "YES" to either 37 or 38, please proceed to question 39.

39. Please list all of the prescription medications you took beginning with the **year prior** to receiving your myopericarditis diagnosis up through the current time.

	Drug Name	Dose	Frequency	Indication	From		To		Currently Using?										
					M	M	Y	Y		Y	Y	M	M	Y	Y	Y	Y		
a.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes
b.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes
c.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes
d.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes
e.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes
f.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes
g.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes
h.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes
i.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes
j.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes

For questions 40- 47 think back to the time you were diagnosed with myopericarditis.

40. In general, would you say your health was: **(Please select only one)**

- Excellent Very good Good Fair Poor

41. In the **month after** receiving your myopericarditis diagnosis, how many hours of sleep did you get in an average 24-hour period?

		hours
--	--	-------

42. About how many times **each week** did you floss your teeth?

- None Once a week 2-3 times/week 4-7 times/week > 7 times/week

43. Other than conventional medicine, what other health treatments did you use **around the time of** your myopericarditis diagnosis?

- a. Mind-body medicine: (e.g. biofeedback, hypnosis, spiritual healing)----- No Yes
- b. Biologically based practices: (e.g. herbal therapy, high dose/megavitamin therapy, homeopathy) -- No Yes
- c. Manipulative and body-based practices: (e.g. acupressure, chiropractic care, massage) ----- No Yes
- d. Energy medicine: (e.g. acupuncture, energy healing, magnet therapy) ----- No Yes

44. Excluding energy drinks, on an **average day**, how many 8-12 oz beverages containing caffeine did you drink (e.g. coffee, tea, soda)?

- None 1-2 per day 3-5 per day 6-10 per day 11 or more per day

45. On an **average day**, how many servings of energy drinks did you drink (e.g. Monster, ROCKSTAR, Red Bull, SoBe Adrenalin Rush, etc.)? NOTE: One can may exceed one serving. For example, one Monster is equal to two servings.

- None 1-2 per day 3-5 per day 6-10 per day 11 or more per day

46. About how many times **each week** did you eat from a fast food restaurant (like hamburgers, tacos, or pizza)?

- None Once a week 2-3 times/week 4-7 times/week 8-14 times/week 15 or more times/week

47. About how many days a **week** did you eat what is described as a heart healthy diet (e.g. ≥ 5 servings of fruit and vegetables a day, low fat protein sources, whole grains, limit unhealthy oils)?

- None Once a week 2-3 days/week 4-6 days/week 7 days/week

48. How tall are you? For example, a person who is 5'8" tall would write 5 feet 08 inches.

	feet			inches
--	------	--	--	--------

49. What was your weight at the time of your myopericarditis diagnosis?

			pounds
--	--	--	--------

50. How much did you weigh a **year prior** to your myopericarditis diagnosis?

			pounds
--	--	--	--------

51. At the time of your myopericarditis diagnosis, how much time did you spend participating in...
(Please mark both your typical "days per week" and "minutes per day" doing these activities)

a. **STRENGTH TRAINING** or work that strengthens your muscles? (e.g. lifting/pushing/pulling weights)

	Days per week
--	---------------

			Minutes per day
--	--	--	-----------------

- None
 Cannot physically do

b. **VIGOROUS** exercise or work that causes heavy sweating or large increases in breathing or heart rate? (e.g. running, active sports, marching, biking)

	Days per week
--	---------------

			Minutes per day
--	--	--	-----------------

- None
 Cannot physically do

c. **MODERATE** or **LIGHT** exercise or work that causes light sweating or slight increases in breathing or heart rate? (e.g. walking, cleaning, slow jogging)

	Days per week
--	---------------

			Minutes per day
--	--	--	-----------------

- None
 Cannot physically do

52. Choose the single best description of your **USUAL** daily activities, at the time of your myopericarditis diagnosis.

- You sit during the day and do not walk much.
 You stand or walk a lot during the day, but do not carry or lift things often.
 You lift or carry light loads, or climb stairs or hills often.
 You do heavy work or carry heavy loads often.

53. At the time of your myopericarditis diagnosis, how much time did you spend sitting and watching TV or videos or using a computer?

		Hours per day
--	--	---------------

54. The following questions ask how often you felt or behaved a certain way. In the **MONTH** following your myopericarditis diagnosis, how often did you/have you...

	Never	Almost Never	Some- times	Fairly Often	Very Often
a. been upset because of something that happened unexpectedly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. felt that you were unable to control the important things in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. felt nervous and/or stressed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. dealt successfully with irritating life hassles?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. felt that you were effectively coping with important changes that were occurring in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. felt confident about your ability to handle your personal problems?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. felt that things were going your way?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. found that you could not cope with all the things that you had to do?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. been able to control irritations in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. felt you were on top of things?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. been angered because of things that happened that were outside of your control?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. found yourself thinking about things that you have to accomplish?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. been able to control the way you spend your time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. felt difficulties were piling up so high that you could not overcome them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

These next few questions are about drinking alcoholic beverages. Alcoholic beverages include liquor such as whiskey, gin, beer, wine, wine coolers, etc. For the purpose of this questionnaire:

One drink = one 12-ounce beer, one 4-ounce glass of wine, or one 1.5-ounce shot of liquor

55. In the **year prior** to your myopericarditis diagnosis, how often did you have a drink containing alcohol?

- Never
 Monthly or less
 2-4 times a month
 2-3 times a week
 4 or more times a week

If you marked "Never," skip to question 60.

56. In the **year prior** to your myopericarditis diagnosis, on those days that you drank alcoholic beverages, on average, how many drinks did you have? -----

		drinks
--	--	--------

57. In the **year prior** to your myopericarditis diagnosis, how often did you have 5 or more alcoholic beverages on one occasion?

- Never
 Monthly or less
 2-4 times a month
 5-10 times a month
 11 or more times a month

58. In a **typical week** following your myopericarditis diagnosis, how many drinks of alcoholic beverages did you have?

Monday

--	--

Tuesday

--	--

Wednesday

--	--

Thursday

--	--

Friday

--	--

Saturday

--	--

Sunday

--	--

59. Review the answers you provided to question 58.

Does this represent the number of alcoholic beverages you drank in a typical week following your myopericarditis diagnosis?

- No, I usually drink LESS than this amount
 No, I usually drink MORE than this amount
 Yes, this represents how much I drink in a typical week

60. In the **year prior** to your myopericarditis diagnosis, did you use any of the following tobacco products?

- a. Cigarettes No Yes
- b. Cigars No Yes
- c. Pipes No Yes
- d. Smokeless tobacco (chew, dip, snuff) No Yes

61. Have you ever smoked at least 100 cigarettes (5 packs)? No Yes

If you marked "YES," please continue to question 62.

62. At what age did you start smoking? years old

63. How many years have or did you smoke an average of at least 3 cigarettes per day
(or one pack per week)? years

64. When smoking, how many packs per day did you or do you smoke?

- Less than half a pack per day
- Half to 1 pack per day
- 1 to 2 packs per day
- More than 2 packs per day

65. Have you ever tried to quit smoking?

- Yes, and succeeded
- Yes, but not successfully
- No

**Thank you for taking the time to complete this survey. If you have any questions or concerns regarding this survey, please contact us at:
NHRC-VaccineRegistry@med.navy.mil**

Because of your frequent military moves, please provide contact information for someone who will always know your whereabouts.

Alternative point of contact:

Last Name:	<input type="text"/>	First Name:	<input type="text"/>	Middle Initial:	<input type="text"/>
Relationship:	<input type="text"/>				
Address Line 1:	<input type="text"/>				
Address Line 2 (optional):	<input type="text"/>				
City (or FPO/APO):	<input type="text"/>				
State/Province/Region (or AA/AE/AP):	<input type="text"/>	ZIP/Postal Code:	<input type="text"/>		
Country:	<input type="text"/>				
Phone number:	<input type="text"/>				
Email address:	<input type="text"/>				