

ACAM2000® Myopericarditis Registry Follow-up

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Subject ID

[] For office use only

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 date of birth?

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

5. What is your **current** weight?

<input type="text"/>	<input type="text"/>	<input type="text"/>
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pounds

6. What is your current military status?

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

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

<input type="text"/>	-	<input type="text"/>	<input type="text"/>
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8. 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

9. 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

10. Have you received any vaccinations since the time covered in your last survey?

- No
- Yes

If you marked "NO," to question 10 skip to question 12.
If you marked "YES" please proceed to question 11.

11. Please list all the vaccinations you have received since the time covered in your last survey.

<p>a. <input style="width: 200px;" type="text"/> <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/></p> <p>b. <input style="width: 200px;" type="text"/> <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/></p> <p>c. <input style="width: 200px;" type="text"/> <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/></p>	<p>d. <input style="width: 200px;" type="text"/> <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/></p> <p>e. <input style="width: 200px;" type="text"/> <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/></p> <p>f. <input style="width: 200px;" type="text"/> <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/></p>
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12. Since the time covered in your last survey:

- a. Have you had a biological grandmother(s), mother, or sister(s) under the age of 65 develop heart disease? No Yes Unsure
- b. Have you had a biological grandfather(s), father, or brother(s) under the age of 55 develop heart disease? No Yes Unsure
- c. Have you had a first degree relative (for example, mother, father, sister, or brother) under the age of 50 develop a heart condition? No Yes Unsure
- d. Has someone in your family been diagnosed with Myocarditis or Pericarditis? No Yes Unsure

13. Since the time covered in your last survey, have you been diagnosed with any medical conditions and/or have you received treatment for any medical conditions? (please consider cardiac and non-cardiac conditions) No Yes

If **YES**, please specify:

14. Since the time covered in your last survey, have you had 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 have NOT experienced chest pain since completing your last survey, please skip to question 17 on page 4.
If you marked "YES" to question 14e, please proceed to question 15.

15. The following questions relate to the chest pain you have experienced since completing your last survey.
Does 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 | | | |

describe other chest pain

16. The following questions ask how much your **heart condition** affected your life during the **past 4 weeks**. 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 **PAST 4 WEEKS** by:

- | | 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 |

Question 16 continued...

Did your **heart condition** prevent you from living as you wanted during the **PAST 4 WEEKS** by:

	No	Very Little	Moderately	Very Much		
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

17. Have you taken over the counter or prescription non-steroidal anti-inflammatory drugs (NSAIDs) in the **past six months**? 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

If you marked "NO," to question 17, please skip to question 19.
If you marked "YES" , please proceed to question 18.

18. Please list all of the NSAIDs (over the counter and/or prescription) that you have taken in the past six months.

	Type/name of NSAID	Dose (in mg)	Frequency					
			More than once a day	Daily	4-6 times a week	2-3 times a week	Weekly	Rarely
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"/>

19. 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: /

20. Are you **currently** taking any prescription medications?

No Yes

If you marked "NO," to question 20, please skip to question 22.
If you marked "YES", please proceed to question 21.

21. Please list all of the prescription medications you are **currently** taking.

	Drug Name	Dose	Frequency	Indication
a.	<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"/>
c.	<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"/>
e.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

Excellent

Very good

Good

Fair

Poor

23. Over the **past month**, how many hours of sleep did you get in an average 24-hour period?

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 hours

24. About how many times **each week** do you floss your teeth?

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

25. Other than conventional medicine, what other health treatments have you used **in the last 6 months**?

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

26. Excluding energy drinks, on an **average day**, how many 8-12 oz beverages containing caffeine do 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

27. On an **average day**, how many servings of energy drinks do 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

28. About how many times **each week** do 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

29. About how many days a **week** do 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
-

30. In a **typical week**, how much time do 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) | <input style="width: 30px; height: 30px;" type="text"/>
Days per week | <input style="width: 30px; height: 30px;" type="text"/> <input style="width: 30px; height: 30px;" type="text"/> <input style="width: 30px; height: 30px;" type="text"/>
Minutes per day | <input type="radio"/> None
<input type="radio"/> 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) | <input style="width: 30px; height: 30px;" type="text"/>
Days per week | <input style="width: 30px; height: 30px;" type="text"/> <input style="width: 30px; height: 30px;" type="text"/> <input style="width: 30px; height: 30px;" type="text"/>
Minutes per day | <input type="radio"/> None
<input type="radio"/> 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) | <input style="width: 30px; height: 30px;" type="text"/>
Days per week | <input style="width: 30px; height: 30px;" type="text"/> <input style="width: 30px; height: 30px;" type="text"/> <input style="width: 30px; height: 30px;" type="text"/>
Minutes per day | <input type="radio"/> None
<input type="radio"/> Cannot physically do |
-

31. Choose the single best description of your **USUAL** daily activities.

- 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.
-

32. On a **typical day**, how much time do you spend sitting and watching TV or videos or using a computer?

Hours per day

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

33. In the **past 6 months**, 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 36.

34. In the **past 6 months**, on those days that you drank alcoholic beverages, on average, how many drinks did you have?

		drinks
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35. In the **past 6 months**, 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

36. In the **past 6 months**, have you used 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

If you marked a "YES," go to question 37.
If you marked all "NO," skip to question 38.

37. 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

38. Have you ever tried to quit smoking?

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

39. The following questions ask how often you felt or behaved a certain way.
In the past **MONTH**, how often 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"/>

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"/>				

**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**