9001538848

Subject ID

ACAM2000® Myopericarditis Registry

[ ] Consent

[ ] 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

- 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

4. What is your sex? ○ Male ○ Female

5. What is your date of birth?

M M / D D / Y Y Y Y — 1 9

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.		/	f.		/
b.		/	g.		/
c.		/	h.		/
d.		/	i.		/
e.		/	j.		/

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

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?	○ No	○ Yes, me	○ Yes, contact
b.	Ever had an organ or bone marrow transplant?	○ No	○ Yes, me	○ Yes, contact
c.	Have a disease that affects the immune system like HIV/AIDS, lymphoma, leukemia, or a primary immune deficiency disorder?	○ No	○ Yes, me	○ Yes, contact
d.	Have systemic lupus erythematosis or another severe autoimmune disease that may weaken the immune system?	○ No	○ Yes, me	○ Yes, contact
e.	Have Darier's disease, a skin disease that usually begins in childhood?	○ No	○ Yes, me	○ 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)?	○ No	○ Yes, me	○ 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?	○ No	○ Yes, me	○ 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?	○ No	○ Yes, me	○ 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)?	○ No	○ Yes, me	○ Yes, contact
c.	Had radiation therapy in the 3 months prior to receiving the smallpox vaccine?	○ No	○ Yes, me	○ 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)?	○ No	○ Yes
b.	Cardiomyopathy (heart muscle becomes enlarged and doesn't work as it should)?	○ No	○ Yes
c.	Congestive heart failure?	○ No	○ Yes
d.	Stroke or transient ischemic attack (a "mini-stroke" that produces stroke-like symptoms but no lasting damage)?	○ No	○ Yes
e.	Chest pain or shortness of breath with activity (such as walking up stairs)?	○ No	○ Yes
f.	Chest pain unrelated to physical activity?	○ No	○ Yes
g.	Chest pressure?	○ No	○ Yes
h.	Palpitations/pounding heart unrelated to physical activity (such as walking up stairs)?	○ No	○ Yes
i.	Abnormal ECG (electrocardiogram)?	○ No	○ Yes
j.	Myocarditis and/or pericarditis?	○ No	○ Yes
k.	Have you been told by a doctor that you have high blood pressure?	○ No	○ Yes
l.	Have you been told by a doctor that you have high blood cholesterol?	○ No	○ 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?	○ No	○ Yes
n.	Any other heart condition under the care of a doctor?	○ No	○ Yes

→ If "**YES**", please specify: _____

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24. Family cardiac history:

a.	Did your biological grandmother(s), mother, or sister(s) develop heart disease **before** they were 65 years of age?	○ No	○ Yes	○ Unsure
b.	Did your biological grandfather(s), father, or brother(s) develop heart disease **before** they were 55 years of age?	○ No	○ Yes	○ 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?	○ No	○ Yes	○ Unsure
d.	Do you have a family history of myocarditis?	○ No	○ Yes	○ Unsure
e.	Do you have a family history of pericarditis?	○ No	○ Yes	○ Unsure

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

a. Headaches	○ No	○ Yes
b. Memory loss	○ No	○ Yes
c. Psychiatric illness	○ No	○ Yes
d. Seizures	○ No	○ Yes
e. Dizziness/Fainting spells	○ No	○ Yes
f. Numbness or paralysis	○ No	○ Yes
g. Shortness of breath	○ No	○ Yes
h. Blood clots	○ No	○ Yes
i. Asthma (include exercise induced)	○ No	○ Yes
j. Eczema	○ No	○ Yes
k. Diabetes or high blood sugar	○ No	○ Yes
l. Chronic fatigue syndrome	○ No	○ Yes
m. HIV	○ No	○ Yes
n. Meningitis	○ No	○ Yes
o. Encephalitis	○ No	○ 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)	○ No	○ Yes	○ Don't know	
b. Enterovirus	○ No	○ Yes	○ Don't know	
c. Adenovirus	○ No	○ Yes	○ Don't know	
d. Parvovirus B19	○ No	○ Yes	○ Don't know	
e. Human Herpesvirus 6	○ No	○ Yes	○ Don't know	
f. Epstein-Barr virus	○ No	○ Yes	○ Don't know	
g. Influenza (flu)	○ No	○ Yes	○ Don't know	
h. Lyme disease	○ No	○ Yes	○ Don't know	
i. Other	○ No	○ Yes	○ Don't know	

→ If other, please specify:

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)	○ No	○ Yes	○ Unknown	M M / Y Y Y Y
b. Cardiac stent procedure	○ No	○ Yes	○ Unknown	M M / Y Y Y Y
c. Bypass surgery (CABG or "cabbage," coronary artery bypass graft, or open heart surgery)	○ No	○ Yes	○ Unknown	M M / Y Y Y Y
d. Minimally invasive heart surgery (including robot assisted heart surgery)	○ No	○ Yes	○ Unknown	M M / Y Y Y Y
e. Artificial heart valve surgery (heart valve replacement surgery)	○ No	○ Yes	○ Unknown	M M / Y Y Y Y
f. Artherectomy	○ No	○ Yes	○ Unknown	M M / Y Y Y Y
g. Radio frequency ablation (catheter ablation)	○ No	○ Yes	○ Unknown	M M / Y Y Y Y
h. Cardiomyoplasty (experimental procedure)	○ No	○ Yes	○ Unknown	M M / Y Y Y Y
i. Transmyocardial re-vascularization (TMR)	○ No	○ Yes	○ Unknown	M M / Y Y Y Y
j. Pacemaker	○ No	○ Yes	○ Unknown	M M / Y Y Y Y
k. Other	○ No	○ Yes	○ Unknown	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)	○ No	○ Yes
b. Fever	○ No	○ Yes
c. Gastrointestinal symptoms	○ No	○ Yes
d. Shortness of breath	○ No	○ Yes
e. Chest pain	○ No	○ 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?	○ No	○ Yes	e. Worsen when leaning forward while sitting?	○ No	○ Yes
b. Decrease when you lie on your back?	○ No	○ Yes	f. Feel tender when you touch it?	○ No	○ Yes
c. Improve when lying on one side?	○ No	○ Yes	g. Other? (if YES, please describe)	○ No	○ Yes
d. Worsen when lying on one side?	○ No	○ Yes			

_____
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?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
b. Making you sit or lie down to rest during the day?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
c. Making your walking about or climbing stairs difficult?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
d. Making your working around the house or yard difficult?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
e. Making your going places away from home difficult?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
f. Making your sleeping well at night difficult?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
g. Making your relating to or doing things with your friends or family difficult?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
h. Making your working to earn a living difficult?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
i. Making your recreational pastimes, sports or hobbies difficult?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
j. Making your sexual activities difficult?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
k. Making you eat less of the foods you like?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
l. Making you short of breath?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
m. Making you tired, fatigued, or low on energy?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
n. Making you stay in a hospital?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
o. Costing you money for medical care?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
p. Giving you side effects from treatments?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
q. Making you feel you are a burden to your family or friends?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
r. Making you feel a loss of self-control in your life?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
s. Making you worry?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
t. Making it difficult for you to concentrate or remember things?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
u. Making you feel depressed?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 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: More than once a day	Daily	4-6 times a week	2-3 times a week	Weekly	Rarely
a.			○	○	○	○	○	○
b.			○	○	○	○	○	○
c.			○	○	○	○	○	○
d.			○	○	○	○	○	○

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

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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 (M M / Y Y Y Y)	To (M M / Y Y Y Y)	Currently Using?
a.					/	/	○ Yes
b.					/	/	○ Yes
c.					/	/	○ Yes
d.					/	/	○ Yes
e.					/	/	○ Yes
f.					/	/	○ Yes
g.					/	/	○ Yes
h.					/	/	○ Yes
i.					/	/	○ Yes
j.					/	/	○ 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. $\geq$ 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

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

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

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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

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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.

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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?	○	○	○	○	○
b. felt that you were **unable** to control the important things in your life?	○	○	○	○	○
c. felt nervous and/or stressed?	○	○	○	○	○
d. dealt successfully with irritating life hassles?	○	○	○	○	○
e. felt that you were effectively coping with important changes that were occurring in your life?	○	○	○	○	○
f. felt confident about your ability to handle your personal problems?	○	○	○	○	○
g. felt that things were going your way?	○	○	○	○	○
h. found that you could **not** cope with all the things that you had to do?	○	○	○	○	○
i. been able to control irritations in your life?	○	○	○	○	○
j. felt you were on top of things?	○	○	○	○	○
k. been angered because of things that happened that were outside of your control?	○	○	○	○	○
l. found yourself thinking about things that you have to accomplish?	○	○	○	○	○
m. been able to control the way you spend your time?	○	○	○	○	○
n. felt difficulties were piling up so high that you could **not** overcome them?	○	○	○	○	○

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.

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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

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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

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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
☐☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐

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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:		**First Name:**		**Middle Initial:**	
Relationship:					
Address Line 1:					
Address Line 2 (optional)**:**					
City (or FPO/APO)**:**					
State/Province/Region (or AA/AE/AP)**:**		**ZIP/Postal Code:**			
Country:					
Phone number:					
Email address:					