7253320103

ACAM2000® Myopericarditis Registry Follow-up

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

- 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 (expires12/31/2013)
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 date of birth?

M M / D D / Y Y Y Y

[ ][ ] / [ ][1] / [ ][ ][ ][ ]

5. What is your **current** weight? [ ][ ][ ] 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.)

[ ] - [ ][ ]

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.

	Vaccination	M M / Y Y Y Y		Vaccination	M M / Y Y Y Y
a.		/	d.		/
b.		/	e.		/
c.		/	f.		/

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)	○ No	○ Yes
b.	Fever	○ No	○ Yes
c.	Gastrointestinal symptoms	○ No	○ Yes
d.	Shortness of breath	○ No	○ Yes
e.	Chest pain	○ No	○ 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?	○ No	○ Yes
b. Decrease when you lie on your back?	○ No	○ Yes
c. Improve when lying on one side?	○ No	○ Yes
d. Worsen when lying on one side?	○ No	○ Yes
e. Worsen when leaning forward while sitting?	○ No	○ Yes
f. Feel tender when you touch it?	○ No	○ Yes
g. Other? (if YES, please describe)	○ No	○ 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?	○ 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

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?	○ 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

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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.			○	○	○	○	○	○
b.			○	○	○	○	○	○
c.			○	○	○	○	○	○
d.			○	○	○	○	○	○

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: ____________ M M / Y Y Y Y

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.				
b.				
c.				
d.				
e.				

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?

☐☐ 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. biofeeback, hypnosis,spirtual 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. acupressure, 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

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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)

Activity	Days per week	Minutes per day	
a. **STRENGTH TRAINING** or work that strengthens your muscles? (e.g. lifting/pushing/pulling weights)	☐	☐☐☐	○ 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)	☐	☐☐☐	○ 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)	☐	☐☐☐	○ None ○ Cannot physically do

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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.

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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.

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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

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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

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38. Have you ever tried to quit smoking?
   - ○ Yes, and succeeded
   - ○ Yes, but not successfully
   - ○ No

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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?	○	○	○	○	○
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?	○	○	○	○	○

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: ______

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