UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

In re: FLUOROQUINOLONE PRODUCTS LIABILITY LITIGATION

MDL No. 15-2642 (JRT)

- -

This Document Relates to All Actions

PRETRIAL ORDER NO. 7
PLAINTIFF'S FACT SHEET

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1. SCOPE OF ORDER

This Order shall apply to all product liability cases currently pending in the MDL 2642 and to all related actions that have been or will in the future be originally filed in, transferred to, or removed to this Court and assigned thereto (collectively, "these MDL proceedings"). This Order is binding on all parties and their counsel in all such case.

2. PLAINTIFF FACT SHEET

The form Plaintiff Fact Sheet ("PFS") that shall be used in MDL 2642 and all member actions is attached as Exhibit A. In accordance with the schedule set forth below, every Plaintiff in each Member Action shall:

a) Complete and execute a PFS;

b) Serve the completed and executed PFS upon counsel for each Defendant named in the Member Action ("Defendant") in the manner described in Section 5 below;

c) Produce to Defendant all responsive, non-privileged documents in his/her possession and custody that are requested in the PFS;

d) Provide duly executed record release authorizations included with the PFS;

e) Each Plaintiff shall also be required to execute five blank versions of the medical authorizations and two blank versions of the employer authorizations, which shall be held by Plaintiff's Attorney of Record. If Defendant(s) learn of a healthcare provider or employer not identified in the PFS, Defendant(s) may request Plaintiff's Attorney of Record to complete one of the blank authorizations for the release of the records from such provider in the format attached to the PFS; and

f) Serve courtesy copy of the PFS and associated materials upon Plaintiffs' Executive Committee in the manner described in Section 5 below.

3. DEADLINE FOR SERVICE IN CURRENT CASES

For all cases assigned to MDL 2642 as of April 21, 2016, Plaintiff shall complete and serve a PFS no later than July 20, 2016.

4. DEADLINE FOR SERVICE IN FUTURE CASES

For all cases assigned to MDL 2642 after April 21, 2016, Plaintiff shall complete and serve a PFS no later than 60 days after the case becomes part of these MDL proceedings.

5. SERVICE OF PFS

Plaintiffs shall serve the completed PFS and authorizations upon a Defendant by emailing them to the following for each Defendant:

a) **Janssen Defendants**: Janssen-FQ-PFS@btlaw.com

b) **Bayer Defendants:** Bayer-FQ-PFS@kayescholer.com

c) **Merck Defendants:** Merck-FQ-PFS@kayescholer.com

Service by email to the above email address shall constitute effective service of the PFS upon Defendant. As additional Defendants are served, or the above email addresses change, they will be added, as necessary, to this order, and/or notice shall be provided to the PEC by contacting Thomas Sims, at Baron and Budd at tsims@baronbudd.com.

Concurrent with service to Defendant, Plaintiff shall serve the completed PFS and authorizations upon the PEC by emailing them to Thomas Sims, at Baron and Budd at tsims@baronbudd.com.

DATED: April 25, 2016
at Minneapolis, Minnesota.

JOHN R. TUNHEIM
Chief Judge
United States District Court

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

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IN RE: FLUOROQUINOLONE PRODUCTS
LIABILITY LITIGATION

MDL NO. 2642

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PLAINTIFF: _____
(name(s))

PLAINTIFF FACT SHEET FOR FLUOROQUINOLONE NEUROPATHY CLAIMS

Please provide the following information for each individual on whose behalf a claim is being made. If you are completing this Plaintiff Fact Sheet in a representative capacity, please respond to the remaining questions with respect to the person who was exposed to fluoroquinolones. Whether you are completing this fact sheet for yourself or for someone else, please assume that "you" or "your" refers to person who was exposed to fluoroquinolones.

As used throughout this form, the term "healthcare provider" refers to any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, as well as any pharmacy, x-ray department, radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, chiropractor, or other persons or entities involved in the diagnosis, care and/or treatment of you.

As used throughout this form, the term "fluoroquinolone" refers to any antibiotic in the fluoroquinolone class of drugs, including, but not limited to the following non-exhaustive list: balofloxacin, besifloxacin, ciprofloxacin, clinafloxacin, enoxacin, flumequine, gatifloxacin, gemifloxacin, grepafloxacin, levofloxacin, lomefloxacin, moxifloxacin, nadifloxacin, norfloxacin, ofloxacin, pazufloxacin, prulifloxacin, sitafloxacin, sparfloxacin, temafloxacin, trovafloxacin, tosufloxacin, as well as their brand-name counterparts (e.g. Avelox®, Cipro®, Floxin®, Levaquin®, etc.).

In completing any section or sub-section of this form, please submit additional pages as necessary to provide complete information. In addition, if you learn that any of your responses are incomplete or incorrect at any time, please supplement your responses to provide that information as soon as you become aware of this information. This form requests information and documents about your medical condition during the last ten (10) years. Defendants reserve the right to request additional information and information for a longer time period on a case-by-case basis, at which time the parties will meet and confer as the issue arises. Further, defendants

expressly reserve the right to request information and documents concerning all exposure(s) you had to fluoroquinolones at any time in your life, regardless of how long ago the exposure took place, and regardless of whether the manufacturer of such fluoroquinolones is a defendant in this action.

I. CASE INFORMATION

1. Name of person on whose behalf a claim is being made: _____

2. If you are completing this Fact Sheet in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following:

    a. Your name, including other names you have used or by which you have been known and dates you used those names: _____

    b. Current address: _____

    c. In what capacity are you representing the individual or estate: _____

    d. If you were appointed as a representative by a court, state the:

        i. Court which appointed you: _____

        ii. Date of appointment: _____

    e. Your relationship to the individual you represent: _____

    f. If you represent a decedent's estate (i.e. the estate of a deceased person), state:

        i. Date of Decedent's death: _____

        ii. Place of the Decedent's death: _____

THE REMAINDER OF THIS FORM REQUESTS INFORMATION ABOUT THE PERSON WHO WAS EXPOSED TO FLUOROQUINOLONES. IF YOU ARE COMPLETING THIS FORM FOR ANOTHER PERSON, PLEASE ASSUME THAT "YOU" MEANS THE FLUOROQUINOLONE USER.

II. PRODUCT IDENTIFICATION

1. Have you ever taken Levaquin, Avelox or Cipro?

   Yes: ____ No: ____

2. Have you ever taken a fluoroquinolone antibiotic other than Levaquin, Avelox, or Cipro?

   Yes: ____ No: ____

3. For ***each*** fluoroquinolone you have ever taken, including, but not limited to Levaquin, Avelox and/or Cipro, please provide the following information. Use additional pages to continue your answer if necessary:

Name of Drug	Date of Prescription	Approx. Date(s) of Use	Dosage	Name of Prescribing Physician	Name and Address of Pharmacy Where Prescription Was Filled	Reason / Condition for Prescription	City and State Where Drug Was Taken

4. Were you ever given any **written** instructions, warnings, or other information about any fluoroquinolone identified above?

   Yes: ____ No: ____

   If you answered **yes**, identify for which specific fluoroquinolone you received written materials, describe the materials you received, identify who provided them, and state whether you or your attorneys still have the materials. (If you have the materials, please produce a copy.):

   _____

   _____

   _____

5. Were you ever given any **verbal** instructions, warnings, or other information about any fluoroquinolone identified above?

   Yes: ____ No: ____

   If you answered **yes**, identify for which specific fluoroquinolone you received verbal information, describe the information you received, when you received it, and identify who provided it:

   _____

   _____

   _____

   _____

6. Did you ever receive samples of any fluoroquinolone you identified above?

   Yes: ____ No: ____

   If you answered **yes**, please state the following:

   a. Who provided the samples? _____

   b. When were the samples provided? _____

   c. Which fluoroquinolone(s) were you provided? _____

7. Did you ever ask any healthcare provider to prescribe you any of the fluoroquinolone(s) identified above?

   Yes: ____ No: ____

III. PERSONAL INFORMATION

1. Full Name: _____

2. Maiden or other names used, including dates you used those names:

   _____

3. Sex: Male: ____ Female: ____

4. Current residence address, including date when you began living at this address:

   _____

5. Identify each address at which you have resided during the last ten (10) years, and the approximate dates you resided at each one.

Street Address, City, State, Zip	Dates of Residence

6. Social Security Number: _____-____-_____

7. Date of birth: ____/____/_____

8. Place of birth: _____

9. Current marital status: **Married**: ____ **Single**: ____ **Widowed**: ____ **Divorced**: ____

10. Spouse's name and date of marriage: _____

11. If you are currently married, has your spouse filed a loss of consortium or other claim in this action?

Yes: ____ No: ____

12. If your spouse is asserting a loss of consortium claim, state his or her occupation:

_____

13. If you have children, please identify each child's name, address, and date of birth:

Child's Name	Street Address, City, State, Zip	Date of Birth

14. Identify all schools you attended, starting with high school:

Name of School	Address and Telephone Number	Dates of Attendance	Degree Awarded	Major or Primary Field of Study

15. Are you currently employed?: Yes: _____ No: _____

If **yes**, please identify your current employer's name, address, and telephone number, and your current position:

_____

_____

If **no**, did you leave your last job for a medical reason? Yes: _____ No: _____

If you left your last job for a medical reason, describe the circumstances under which you left:

_____

16. Please identify all of your employers for the last ten (10) years and provide the following information for each:

Name of Employer	Address and Telephone Number	Dates of Employment	Your Position	Reason for Leaving

17. Have you ever served, or do you currently serve, in any branch of the military, including any military reserve unit or National Guard?:

Yes: _____ No: _____

If **yes**, identify the branch and dates of service: _____

18. Were you ever rejected or discharged from any branch of the military, including the military reserve or National Guard, for any reason relating to your medical, physical or psychiatric condition?:

    Yes: _____ No: _____

    If **yes**, state the reason for which you were rejected or discharged:

    _____

19. Identify each insurance carrier with whom you had health insurance coverage at any time during the last ten (10) years, including identification of all private insurance and public assistance, if applicable:

Name of Insurance Company	Policy Number	Name of Policy Holder / Insured (if not you)	Approximate Dates of Coverage

20. Have you applied for workers' compensation, social security, and/or state or federal disability benefits within the past ten (10) years?

    Yes: _____ No: _____

    If **yes**, then as to each application, separately state the date (or year) of application, the nature of claimed injury or disability, the agency or company to which you submitted your application, and the approximate dates for which you claimed disability:

Date or Year of Application	Nature of Claimed Injury or Disability	Agency / Company to Which You Applied	Approx. Dates for Which You Claimed Disability

21. Excluding the present lawsuit, have you ever filed a lawsuit or made a claim relating to any bodily injury?

Yes: _____ No: _____

If **yes**, please state the following:

Party You Sued / Made Claim Against	Court in Which Suit Filed / Claim Made	Case / Claim Number	Attorney Who Represented You	Nature of Claim and Injury

22. Have you been convicted of, or pled guilty to, a felony and/or a crime of fraud or dishonesty within the past ten years?

Yes: _____ No: _____

If **yes**, please state the charge to which you plead guilty and or of which you were convicted, as well as the court where the action was pending, including the relevant dates:

_____

_____

23. Have you used a personal computer or laptop computer in the last ten (10) years:

Yes: _____ No: _____

If **yes**, please answer the following questions:

a. How long have you owned or had access to the computer:

_____

b. Have you ever used a computer to look for information on the internet about any fluoroquinolone drug(s)?

Yes: _____ No: _____

If you answered yes, identify the specific fluoroquinolone about which you conducted an internet search, describe the information or materials you located and state whether you have a printed copy of the materials. (If you have any materials please produce a copy.):

_____

_____

c. Have any of your family members, friends or anyone else on your behalf ever used a computer to look for information on the internet about any fluoroquinolone drug(s)?

Yes: _____ No: _____

If you answered **yes**, identify the specific fluoroquinolone about which you conducted an internet search, describe the information or materials you located and state whether you have a printed copy of the materials. (If you have any materials please produce a copy.):

_____

_____

d. Have you ever read or posted to any weblogs (blogs), social networking sites (such as Facebook of LinkedIn), or message boards regarding any fluoroquinolone drug(s)?

Yes: _____ No: _____

If you answered **yes**, identify the specific fluoroquinolone about which you posted on the internet, and describe post, including the specific website on which you posted. (If you have a copy of the post please produce a copy.):

_____

_____

e. Have you ever used a computer to look for information on the internet about peripheral neuropathy and fluoroquinolones?

Yes: _____ No: _____

If you answered **yes**, describe the information or materials you located and state whether you have a printed copy of the materials. (If you have any materials please produce a copy.):

_____

_____

f. Have any of your family members, friends or anyone else on your behalf ever used a computer to look for information on the internet about peripheral neuropathy?

Yes: _____ No: _____

If you answered **yes**, describe the information or materials located and state whether you have a printed copy of the materials. (If you have any materials please produce a copy.):

_____

_____

g. Have you ever read or posted to any weblogs (blogs), social networking sites (such as Facebook of LinkedIn), or message boards regarding any fluoroquinolone drug(s)?

Yes: _____ No: _____

If you answered **yes**, describe the post, including the specific website on which you posted. (If you have a copy of the post please produce a copy.):

_____

_____

24. Do you belong to any fluoroquinolone-related information or support groups, either on-line or elsewhere? (e.g. Floxie Hope; Facebook's "Fluoroquinolone Antibiotic Toxicity Community;" Facebook's "Fluoroquinolone Wall of Pain;" The TropicalPenguin Health Forum, etc.)

Yes: _____ No: _____

If you answered **yes**, please provide the following information:

a. The name of the group (or groups) and the date(s) you joined:

_____

b. A description of any written materials you have received from and/or provided to the group and the date they were received and/or provided. (If you have any materials please produce a copy.):

_____

_____

IV. HEALTHCARE PROVIDERS

1. Identify each doctor or other healthcare provider who you have seen for any medical care and treatment in the past ten (10) years:

Name and Specialty	Address and Telephone Number	Approximate Dates / Years of Visit(s)

2. Identify each hospital, clinic, or healthcare facility where you were hospitalized (in-patient, out-patient, or emergency room visit) in the past ten (10) years inclusive of all surgeries and transplants:

Name	Address and Telephone Number	Date(s) of Treatment

3. Identify each pharmacy that has dispensed medication to you in the past ten (10) years:

Name of Pharmacy	Address and Telephone Number of Pharmacy	Approximate Dates / Years You Used Pharmacy

V. MEDICAL BACKGROUND

1. Height: _____ ft., _____ in.

2. Current Weight: _____ lbs.

3. Smoking History

   a. Have you ever smoked cigarettes?

      Yes: _____ No: _____

      If **yes**, state, state the amount smoked: _____ packs per day for _____ years,

      during the years _____ to _____.

   b. Have you ever smoked cigars or pipe tobacco or used smokeless tobacco?

      Yes: _____ No: _____

      If **yes**, state, state the amount smoked/used: _____ cigars/pipes/smokeless tobacco

      for _____ years, during the years _____ to _____.

4. Alcohol Use History

   a. Do you currently drink alcohol (beer, wine, liquor, etc.)?

      Yes: _____ No: _____

      If **yes**, estimate how many alcoholic drinks you ingest per week, on average:

      _____

   b. Please provide the average number of drinks you ingested per week, on average, in the five years prior to the onset of your peripheral neuropathy symptoms (e.g. "an average of 5-10 drinks per week in the five years prior to onset of PN symptoms"): _____

5. Allergies and Allergic Reactions:

   a. Have you ever experienced an allergic reaction to any food, medication or pharmaceutical (including contrast agents)?

      Yes: _____ No: _____

      If yes, please provide the following information:

Food, Medication, or Pharmaceutical	Approximate Date Allergy Diagnosed	Symptoms of Allergy	Healthcare Provider Who Diagnosed Allergy

6. Other Conditions:

   a. To the best of your knowledge, have you ever experienced or been diagnosed with any of the following conditions? Please select **yes** or **no** for each condition. For each condition for which you answer **yes**, please provide the additional information requested in the table following this chart:

	Condition Experienced or Diagnosed	Yes	No
1.	Alcoholism		
2.	Arthritis (including osteoarthritis and rheumatoid arthritis)		
3.	Autoimmune disease or condition (e.g. lupus; rheumatoid arthritis; Sjogren's Syndrome; Guillain-Barre Syndrome; chronic inflammatory demyelinating polyneuropathy)		
4.	Bacterial infection (e.g. diphtheria, Lyme disease, leprosy, typhoid)		
5.	Bleeding or clotting disorders or predispositions		

6.	Bone marrow disorders (e.g. abnormal blood protein, amyloidosis, bone cancer, lymphoma, monoclonal gammpathies, osteosclerotic myeloma)		
7.	Brain or neurological disorder (e.g. tumors, strokes, cerebrovascular disease)		
8.	Cancer (including blood cancers such as leukemia)		
9.	Cardiac condition (e.g. arrhythmia or dysrhythmia, heart attack, angina, congestive heart failure, cardiomyopathy, enlarged heart, coronary artery disease, blocked or narrowed arteries, heart valve conditions)		
10.	Chronic inflammatory conditions, such as inflammatory bowel disease, Crohn's disease or other pro-inflammatory diseases (e.g. Guillain-Barre syndrome, systemic lupus erythematosus, leprosy, multiple sclerosis, Sjogren's syndrome, Lyme disease, sarcoidosis)		
11.	Congenital disorder of any kind		
12.	Celiac disease or other gluten-sensitive condition		
13.	Diabetes (if yes, specify Type 1 or Type 2)		
14.	Disorder or abnormality of blood vessels or circulatory system (e.g. aneurysm, arteriovenous malformation)		
15.	Endocrine condition or disease (e.g. malfunction of the pancreas, parathyroid, thyroid, adrenal or pituitary, hyperparathyroidism, etc.)		
16.	Epstein-Barr virus		
17.	Exposure to chemotherapy medications		
18.	Diagnosis of or known adverse exposure to environmental toxins or poisons (e.g. heavy metals, toxic chemicals, Arsenic)		
19.	Fibromyalgia		
20.	Fractured limb(s)		
21.	Gastrointestinal problems (e.g., ulcers, heartburn, acid reflux, GERD, gallbladder disease, colitis, intestinal obstruction)		
22.	Diagnosed genetic disorder or disease (e.g. Charcot-Marie-Tooth disease; Friedreich's ataxia, hereditary neuropathy, porphyria, Sickle cell anemia		

23.	Hepatitis		
24.	High blood pressure or low blood pressure		
25.	High cholesterol or triglycerides; hyperlipidemia or lipid metabolism disorders		
26.	HIV/AIDS		
27.	Medically-diagnosed impaired glucose tolerance		
28.	Infectious disease (e.g., tuberculosis, pneumonia, rheumatic fever, typhoid fever, encephalitis, poliomyelitis, malaria)		
29.	Joint replacement		
30.	Kidney disease or condition (e.g., renal insufficiency, acute or chronic renal failure, end-stage renal disease, cysts, pruritus of renal disease/ neuropathy, hepatorenal syndrome)		
31.	Liver failure, disorder, or disease (e.g. cirrhosis, hepatitis)		
32.	Lung disease (e.g. chronic obstructive pulmonary disease, chronic lung disease, emphysema, asthma, pulmonary hypertension or other lung disease)		
33.	Lyme disease		
34.	Malaria		
35.	Mumps		
36.	Neurological disease or condition (e.g. multiple sclerosis, ALS, Parkinson’s disease, Alzheimer’s)		
37.	Neuromuscular disorders (e.g. paralysis or any condition affecting movement or mobility)		
38.	Organ transplant		
	Injury you attribute to or have been diagnosed with in relation to repetitive motion		
39.	Sexually transmitted diseases or infections (e.g.: syphilis; gonorrhea; Chlamydia; human herpesvirus, including Epstein-Barr virus, herpes simplex virus; Trichomoniasis)		

40.	Shingles		
41.	Thrombotic events (e.g. heart attack, transient ischemic attack, stroke, deep vein thrombosis, portal vein thrombosis or pulmonary embolism)		
42.	Thyroid disease or disorder		
43.	Traumatic nerve damage (e.g. damage to or pressure on nerves from a traumatic event, such as a motor vehicle accident or sports injury)		
44.	Tumors or tumorous growths (both cancerous and non-cancerous)		
45.	Vascular disease (e.g. peripheral vascular disease, peripheral arterial disease, vasculitis, phlebitis)		
46.			
47.	Diagnosed or otherwise known vitamin deficiency (e.g., B12 deficiency)		

b. For each condition for which you answered **yes** in the previous chart, please provide the information requested below:

Condition You Experienced	Approximate Date of Onset	Name, Address, and Telephone Number of Treating Physician (If Any)

7. Surgeries/Procedures

   a. For each surgery (invasive or non-invasive), procedure or therapy (including radiation therapy, hyperbaric oxygen therapy, immunotherapy, etc.) that you have undergone in the past ten (10) years, please provide the information requested below:

Date	Procedure	Facility	Physician Ordering	Physician Administering or Performing	Purpose

8. History of Peripheral Neuropathy

   a. State the first date (approximate) on which you were ever diagnosed with peripheral neuropathy (regardless of whether that diagnosis was related to the alleged injuries giving rise to the claims being made in this lawsuit):

   _____

   b. For every date on which you were ever diagnosed with peripheral neuropathy, please provide the information requested below:

Condition	Approximate Date of Onset	Name, Address, and Telephone Number of Treating Physician (If Any)	Cause of Peripheral Neuropathy (If Known)

9. Have you ever been diagnosed with a **medication-related** form of peripheral neuropathy prior to the alleged injuries giving rise to the claims made in this lawsuit?

Yes: _____ No: _____

If yes, please state the following:

Condition	Medication Taken	Approximate Date of Onset	Name, Address, and Telephone Number of Treating Physician (If Any)

VI. MEDICATIONS

1. List all of the medications you currently take (attach additional pages if necessary):

Medication	Dose / Frequency	Physician Ordering	Pharmacy Dispensing	Purpose

2. To the best of your recollection, do you currently take or have you ever taken in the past ten (10) years, any of the following medications (whether by prescription or over-the-counter), pharmaceutical products, supplements, or herbal remedies:

Name of Medication	Yes	No	Date(s) Taken and Prescribing Physician	Name and Address of Pharmacy Where Obtained
ANTIBIOTICS / ANTI-INFECTIVES				
Aminoquinolone (e.g. Chloroquine)				
Anitmycobacterials (e.g. Isoniazid)				
Fluoroquinolones (*other* than Avelox, Cipro, or Levaquin; e.g. Floxacin, Omniflox, etc.)				
Nitrofurantoin (e.g. Furadantin, Macrodantin, Macrobid)				
Nitroimidazoles (e.g. Flagyl, Metronidazole)				
Penicillins, including but not limited to Aminopenicillin (e.g. Omnipen, Principen), Amoxicillin (Amoxil, Trimox), Ampicillin				

Thalidomide (e.g. Immunoprin, Talidex, Talizer)				
CANCER TREATMENT DRUGS				
Cisplatin (e.g. Platinol)				
Docetaxel (e.g. Taxotere, Docecad)				
Paclitaxel (e.g. Abraxane, Taxol, Onxol)				
Radiation therapy				
OTHER MEDICATIONS				
Amphetamines				
Anti-alcohol drugs (e.g. disulfiram)				
Anticoagulants				
Anti-depressants				
Anti-epileptic and anti-convulsant drugs (e.g. phenytoin)				
Anti-HIV drugs (e.g. didanosine, stavudine, zalcitabine, Videx, Zerit, Hivid)				
Anti-infective drugs				
Anti-inflammatories				
Anti-psychotic medications				
Anti-rejection medications				
Autoimmune drugs (e.g. Etanercept, Infliximab, Feflunomide)				
Blood pressure medications				
Blood thinners				
Chemotherapy				

Cholesterol medications				
Cholesterol-lowering drugs (e.g., statins)				
Dapsone				
Diabetic medications				
Heart medications				
Herbal remedies				
Hormone therapy				
Immunosuppressive drugs				
Pain medications				
Steroids, whether oral or injected, including but not limited to dexamethasone, prednisone, prednisolone, and methylprednisolone				
Thyroid Medications				
Triglyceride-lowering drugs				
Vitamin B12				

3. If you indicated **yes** to any of the above medications/drugs please provide the following information:

Name of Medication / Drug Used	**Approximate Dates of Use**	**Name, Address, and Telephone Number of Prescribing Physician**	**Purpose / Condition for Which Drug Was Prescribed**

4. To the best of your recollection, are there any prescription medications other than those identified above that you have taken on a regular basis in the last ten (10) years for any duration more than **ten (10) days**?

   Yes: _____ No: _____

   If yes, please provide the following information:

Name of Medication / Drug Used	Approximate Dates of Use	Name, Address, and Telephone Number of Prescribing Physician	Purpose / Condition for Which Drug Was Prescribed

VII. FAMILY MEDICAL HISTORY

1. Please indicate, to the best of your knowledge, whether your parents, siblings, children or grandparents have ever experienced or been diagnosed with any of the conditions listed above in Section VI. For any such conditions, please indicate which one(s) and provide the following information. If to your knowledge, no parents, siblings, children or grandparents have ever experienced or been diagnosed with any of the conditions listed above in Section VI, please check the box indicating "None.":

Condition	Approximate Date of Onset	Relationship to You	Treatment	Outcome	None

2. Please indicate, to the best of your knowledge, whether your parents, siblings, children or grandparents have ever experienced or been diagnosed with peripheral neuropathy ? Please indicate which one(s) and provide the following information. If to your knowledge, no parents, siblings, children or grandparents have ever experienced or been diagnosed with peripheral neuropathy or any other neurological disorder, please check the box indicating "None.":

Condition	Approximate Date of Onset	Relationship to You	Treatment	Outcome	None

VIII. INJURIES & DAMAGES

1. Are you claiming any injury as a result of exposure to fluoroquinolones?

   Yes: _____ No: _____

   If **yes**, please describe in detail any injury(ies) you claim were caused as result of your exposure to fluoroquinolones:

   _____

   _____

2. Date Plaintiff first experienced symptoms of a physical injury?

   _____

3. Have you ever been treated by a health care provider (other than a hospital) for any of these injuries?

   Yes: _____ No: _____

   If **yes**, please provide the following information:

   a. Approximate date(s) of treatment: _____

   b. Name and address of healthcare providers:

   _____

4. Are you claiming that exposure to fluoroquinolones caused you to develop peripheral neuropathy ?

   Yes: _____ No: _____

   If **yes**, please answer the following questions:

   a. Have you been diagnosed with any of these conditions? Yes: _____ No: _____

   b. What healthcare provider diagnosed you with any these conditions and when?_____

c. Date Plaintiff first experienced peripheral neuropathy symptoms?
_____

d. What treatment have you undergone or are you undergoing?
_____

e. What treatment options were considered? _____

f. Did the condition resolve? Yes: _____ No: _____

5. Have you ever been hospitalized as a result any of these conditions or injuries?

Yes: _____ No: _____

If **yes**, please answer the following questions:

a. Approximate date(s) of hospital admission: _____

b. Approximate date(s) of discharge:_____

c. Hospital name(s) and address(es):_____

6. Do you claim in this lawsuit that your exposure to fluoroquinolones caused or aggravated any psychiatric and/or psychological condition(s)?

Yes: _____ No: _____

If **yes**, please state the following as it pertains to your treatment for any psychiatric and/or psychological condition(s) since the age of 18 (or, if under 18, since birth):

Condition You Experienced	**Name, Address, and Telephone Number of Mental Healthcare Provider (If Any)**	**Approximate Dates / Years of Treatment / Visits (If Any)**

7. Are you making a claim for lost wages or lost earning capacity?

   Yes: _____ No: _____

   If **yes**, please describe your claim and attach your W-2 forms or other tax documents for the past five (5) years:

   _____

   _____

8. Are you claiming any out of pocket expenses as a result of your use of fluoroquinolones?

   Yes: _____ No: _____

   If **yes**, please itemize those expenses and provide the amount of each such expense:

   _____

   _____

9. Have you had any communications with your healthcare providers, orally or in writing, about whether your condition is related to your use of fluoroquinolones?

   Yes: _____ No: _____

   If **yes**, please identify the name, address, and approximate date of communication with said healthcare provider:

   _____

   _____

IX. FACT WITNESSES

1. Please identify all persons whom you believe possess information concerning your injury(ies) and current medical conditions, other than your healthcare providers, and please state their name, address, and relationship to you.

_____

_____

_____

_____

_____

_____

_____

_____

X. DECEASED INDIVIDUALS AND AUTOPSY INFORMATION

1. Are you completing this Plaintiff Fact Sheet on behalf of an individual who is deceased?

   Yes: _____ No: _____

   If **yes**, please provide the following information from the Death Certificate of the individual:

   (**NOTE**: In lieu of the following, please attach a copy of the death certificate.)

   Date of death: ____/____/_____

   Place of death (city, state and county): _____

   Facility or location where death occurred: _____

   Name of physician who signed death certificate: _____

   Cause of death: _____

2. Do you contend that the deceased person's death was caused by or related to the ingestion of fluoroquinolones?

   Yes: _____ No: _____

3. Are you completing this Plaintiff Fact Sheet on behalf of an individual who is deceased and on whom an autopsy was performed?

   Yes: _____ No: _____

   If **yes**, please provide the following information pertaining to the autopsy/autopsy report:

   (**NOTE**: In lieu of the following, please attach a copy of the autopsy report.)

   Date of autopsy: ____/____/_____

   Identity of person who performed autopsy:_____

   Facility where autopsy was performed:_____

   Place where autopsy performed (city, state, county):_____

   Describe any and all tissue preserved:_____

XI. DOCUMENT DEMANDS

1. Authorizations: Please sign authorizations that are attached hereto as **Exhibit A**, for each of the healthcare providers that you have identified above.

2. Please provide a copy of all your documents, including writings on paper or in electronic form, which fall into the categories listed below: This includes documents in your custody, possession, or control.

   a. All non-privileged documents you reviewed that assisted you in the preparation of the answers to this Plaintiff Fact Sheet

   b. Any and all of your medical records, medical billing records, or insurance records in your possession, custody, or control.

   c. Copies of the entire packaging, including the bottle, box, label, and package insert for any fluoroquinolone(s) you have ever been prescribed, as well as any remaining medication, and any pharmacy packaging and receipts for any fluoroquinolone prescriptions.

   d. Copies of the entire packaging, including the bottle, box, label, and package insert, as well as any remaining medication, and any pharmacy packaging and receipts for any other prescription medication you took while taking a fluoroquinolone.

   e. Copies of advertisements or promotions for any fluoroquinolone(s) you have ever been prescribed and articles discussing fluoroquinolones.

   f. A copy of all medical records and/or documents relating to the exposure to any fluoroquinolone(s) at any time in your life.

   g. Any and all records which reflect or are related to a diagnosis of any neurologic injury or condition, or any allegedly related conditions.

   h. All documents in your possession, custody or control, concerning or relating to any fluoroquinolone(s) you have ever been prescribed and/or all defendants in this lawsuit.

   i. All documents in your possession, custody or control, concerning or relating to peripheral neuropathy, or any allegedly related conditions.

   j. All documents in your possession, custody or control which were provided to you by any of the parties you have sued, or any pharmacy that distributed any fluoroquinolone(s) you have ever been prescribed.

   k. All documents constituting any communications or correspondence between you and any representative of the parties you have sued, or any pharmacy that distributed any fluoroquinolone(s) you have ever been prescribed.

l. All photographs, drawings, diaries, journals, calendars, notes, slides, videos, DVDs or any other media relating to your alleged injury(ies) or your life after your alleged injuries began.

m. If you claim you have suffered a loss of earnings or earnings capacity, your federal tax returns for each of the last five (5) years or W-2s or other tax documents, such as 1099s, for each of the last five (5) years.

n. Documents relating to any claim for damages, including, but not limited to, medical, hospital, pharmacy or other bills.

o. Copies of letters testamentary or letters of administration relating to your status as plaintiff (if applicable).

p. Decedent's death certificate and autopsy report (if applicable).

XII. VERIFICATION

I, _____, declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge upon information and belief, that I have supplied all the documents requested in part IX of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and that I have supplied the authorizations attached to this declaration.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in some material respects incomplete or incorrect.

Date: _____ **_____**

Signature

AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS

TO: _____

_____

_____

_____

RE: _____

DOB: _____

SSN: _____

This will authorize a representative of _____, or their agents or representatives to obtain any and all information pertaining to my employment including but not limited to, my personnel file, benefits file, payroll records, FMLA records, workers' compensation, and any and all reports of medical examinations and/or medical history in your files, and to make photocopies of all or any portion thereof.

A photostatic copy of this authorization shall be as valid and may be used and relied on with the same force and effect as the signed original thereof.

Date: _____ _____

Signature

2

TO: Social Security Administration; OEO FOIA Workgroup:

INFORMATION REQUEST

Name	DOB	SSN

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS

I want this information released because:

Litigation

(There may be a charge for releasing information)

Please release the following information:

x Social Security Number

x Identifying information (included data and place of birth, parents' names)

x Monthly Social Security benefit amount

x Monthly Supplemental Security Income payment amount

x Information about benefits/payments I received from _____ to_____

x Information about my Medicare claim/coverage from _____ to_____

(specify)_____

x Medical records

3

Record(s) from my file (specify)_____

_____

Other (specify)_____

I am the individual to whom the information/record applies or the parent or legal guardian of that person. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature:_____

(Show signature, names, and addresses of five people if signed by mark.)

Date: _____ Relationship:_____

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AUTHORIZATION FOR RELEASE OF WORKERS' COMPENSATION RECORDS

TO: Department of Labor and Industry

FROM Name: _____

SSN: _____

DOB: _____

I hereby authorize _____, or their agent or representative, to inspect, review and obtain copies of any and all injury reports, notices, medical reports, payment records, statements, orders and all other documents contained in all Workers' Compensation files relating to _____.

Date: _____ _____

Signature

AUTHORIZATION FOR RELEASE OF MEDICAL

RECORDS PURSUANT TO 45 CFR 164.508 (HIPAA)

TO: _____

NAME: _____

DOB: _____

SSN: _____

I, _____, authorize you to disclose and release the following protected health information for the **WRITTEN MEDICAL RECORDS**: any and all medical records, all inpatient and outpatient charts and records, hospital charts and records, doctor and nurse notes, emergency room records, clinic notes, correspondence, memoranda, physical therapy and rehabilitation records, patient questionnaire forms, patient history forms, social service records, laboratory reports, diagnostic reports, any and all photographs. **DIAGNOSTIC TESTS OR IMAGING:** operative photographs, videotapes, transcripts/tracings, slides, x-ray films, audio tapes. **PATHOLOGY:** any and all pathology. **RADIOLOGY**: written or recorded results or reports of any genealogical, bone, joint, muscle, tissue, blood, heart, lungs, cartilage, ligaments, vertebral bodies, brain, and/or nervous system and any and all films, studies, tracings or the like, including, but not limited to x-rays, MRI films, CAT scans, brain scans, bone scans, and EKG and EMG tracings in all forms. **PRESCRIPTION RECORDS:** any and all prescription records, the issuance of sale of prescription drugs, original doctor's prescription forms, refill records and pharmacy records. **PROTOCOL**: any and all documents describing the protocol and criteria for administration and interpretation of diagnostic tests or imaging. **BILLING**: any and all billing records, including itemized statements of charges, payments, all insurance records, including all claims, claim forms, correspondence, payments and reports. I authorize you to disclose the aforementioned records in your possession, custody, and control, regardless of whether those records were generated by this facility or by a third party facility.

Also, please disclose and release the following protected health care information (only if checked below):

___x___ Drug and Alcohol Records

_____ HIV and AIDS Records

___x___ Mental Health Records

This protected health information is disclosed for the following purposes: Personal Injury/product liability lawsuit.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

_____

Name of Representative(s)

_____

Representative Capacity (e.g. attorney, records requestor, agent, etc.)

_____

Street Address

_____

City, State and Zip Code

This authorization shall be in force and effect until one year from the date signed below, at which time this authorization expires. I have the right to revoke this authorization, in writing, by sending written notification to you. I understand that a revocation is not effective to the extent that you have relied on my authorization to disclose protected health information. A photostatic copy of this authorization shall be valid and may be used and relied upon with the same force and effect as the signed original. I understand that the information may be redisclosed and no longer subject to protection. I understand that I have the right to:

_____ Inspect or copy the individually identifiable health information to be disclosed and/or this authorization.

_____ Refuse to sign this authorization, and that refusal to sign will not affect my right to continue to receive further care and treatment from the health care provider identified in this authorization.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority to Sign for Patient (attach documents which show authority)