Exhibit B

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

IN RE: Stryker Rejuvenate and ABG II Hip Implant Products Liability Litigation	MDL No. 13-2441 (DWF/FLN)
This Document Relates to:	**PLAINTIFF FACT SHEET**

Please provide the following information for each individual who has filed a complaint or on whose behalf a complaint has been filed in the *In Re: Stryker Rejuvenate and ABG II Hip Implant Products Liability Litigation*, MDL No. 13-2441. If you are completing this Plaintiff Fact Sheet in a representative capacity, please respond to the remaining questions with respect to the person who had the Rejuvenate or ABG II Hip System implanted.

In completing this Plaintiff Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge, information and belief. If the response to any question is that the person completing this Plaintiff Fact Sheet does not know or does not recall the information requested, that response should be entered in the appropriate location(s). You may and should consult with your attorney if you have any questions regarding the completion of this form.[1]

In filling out any section or sub-section of this form, please submit additional sheets 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 the corrected or additional information within fourteen (14) days of when you become aware of this information. This form requests information and documents about your medical condition for a specified period of time. However, Defendant reserves the right to request additional information and information for a time period dating further back on a case by case basis.

In filling out this form please use the following definitions:

"Healthcare Provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, psychiatric, mental, emotional or psychological care or advice, and any pharmacy, counselor, dentist, x-ray department, radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, nurse, herbalist, nutritionist, dietician or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you.

"You" or "Your" means the person who had the Device(s) implanted.

"The Device" refers to the Rejuvenate Modular Hip System or ABG II Modular Hip System that was implanted in you.

[1] This Plaintiff Fact Sheet constitutes discovery responses subject to the Federal Rules of Civil Procedure.

I. CASE INFORMATION

1. Name of individual(s) who has/have filed a complaint or on whose behalf a complaint has been filed (first, middle name or initial, last): _____

2. Name of person signing this form, if different than above: _____

3. Please state the following for the civil action that you filed: _____

   Case Caption: _____

   Docket Number: _____

   Court in which action was originally filed: _____

   Name, address, telephone number, fax number and e-mail address of the attorney you retained and the principal attorney representing you, if different:

   Name: _____

   Firm: _____

   Address: _____

   Telephone Number: _____ Fax Number: _____

   E-mail Address: _____

4. Only if you are completing this Plaintiff Fact Sheet in a representative capacity (e.g., on behalf of the estate of a deceased person), 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:

      Court which appointed you:_____

      Date of Appointment: _____

   e. What is your relationship to the individual you represent:_____

   f. If you represent a decedent's estate, please state the date and cause of decedent's death: _____

_____

<u>INSTRUCTION:</u> THE REST OF THIS PLAINTIFF FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO WAS IMPLANTED WITH THE DEVICE(S) AT ISSUE.

II. CORE MEDICAL INFORMATION

A. <u>Prior to receiving the Device(s) at issue, had you ever received any other joint prosthesis or implant?</u>

Yes _____ No _____

1. Type of joint prosthesis or implant(s) received: _____

_____

2. Date(s) (including month(s) and year(s)) you received the joint prosthesis or implant(s): _____

_____

3. Name(s) and address(es) of the physician(s) who performed your joint prosthesis or implant surgery(ies): _____

_____

4. Name(s) and address(es) of the hospital at which your joint prosthesis or implant surgery(ies) were(was) performed: _____

_____

5. Date(s) (including month(s) and year(s)) of any revision surgery(ies) you underwent for the joint prosthesis or implant(s) referenced in response to this question: _____

_____

6. Name(s) and address(es) of the physician(s) who performed your revision surgery(ies) for the joint prosthesis or implant(s) referenced in response to this question: _____

_____

_____

7. Name(s) and address(es) of the hospital(s) at which your revision surgery(ies) was(were) performed for the joint prosthesis or implant(s) referenced in response to this question: _____

_____

_____

8. Reason(s) for your revision surgery(ies) for the joint prosthesis or implant(s) referenced in response to this question: _____

_____

B. Regarding the Device(s) at issue in this lawsuit, please state:

1. Implant Date(s): _____
2. Identify the Device(s) at issue in this lawsuit that you received by the name, catalog number(s), and lot number(s) of each component (stem and neck): _____

_____

Side of Body (for implant at issue): Right _____ Left _____ Both _____ (check one)

3. Name and Address of Implanting Surgeon(s): _____

_____

_____

4. Name and Address of Hospital(s) or Clinic(s) where implant surgery(ies) performed: _____

_____

_____

5. Revision Date(s) (if applicable): _____
6. If you have undergone revision surgery:
   a. Did any medical providers tell you that you required a revision of the Device(s) due to a defect in the Device(s)? If yes, identify the medical providers (including names and addresses), provide date(s) (including month and year) you were told and describe in detail exactly what you were told regarding a defect in the Device(s):_____

_____

_____

b. Provide the date of *each* revision surgery and the name and address of the surgeon(s) who performed *each* revision surgery:_____

_____

_____

c. Provide the name and address of the facility at which each revision surgery was performed:

_____

_____

_____

7. Please describe what components of the Device were removed during the revision surgery:

_____

_____

8. a. Were the explanted components preserved? Yes _____ No _____

b. If Yes, list the name and address for the person or entity that has possession of the explanted components and all those who had possession at any time (chain of custody):

_____

_____

9. If you had a revision surgery, provide the name of the Manufacturer and size of the replacement device, if any: _____

_____

10. a. Did you pay for your *revision surgery* and all related care?

Yes _____ No _____ In Part _____

i. If Yes, provide the amount paid by you: _____

ii. If No or In Part, state who or who else paid for the revision surgery: _____

_____

iii. Provide the approximate amount paid by each person and entity and identify each person

and insurance carrier, including but not limited to payments by Medicare and Medicaid, and for carriers, provide the name, address, and policy number:

_____

_____

b. Did you pay for your *initial surgery* and all related care?

Yes _____ No _____ In Part _____

i. If Yes, provide the amount paid by you: _____

ii. If No, or In Part, state who or who else paid for the surgery and all related care:

_____

_____

iii. Provide the approximate amount paid by each person and entity and identify each person and insurance carrier, including but not limited to payments made by Medicare and Medcaid, and for carriers, provide the name, address, and policy number:

_____

_____

11. If you have not had any components of your Device(s) removed surgically, do you presently plan to have any of the components removed? Yes _____ No _____ Undecided _____

If Yes, please state:

The date(s) scheduled for the surgery to remove/replace the Device(s): _____

_____

The name and address(es) of the surgeon(s): _____

_____

The name and address(es) of the hospital(s) where the surgery will be performed: _____

_____

_____

The reason for surgery: _____

_____

12. Has any doctor ever told you that you need to have any components of your Device(s) removed?

    Yes _____ No _____

    If Yes, please provide the name and addresses of each such doctor and the dates and substance of those discussions: _____

    _____

13. Has any doctor told you that your medical condition prevents you from having any components of your Device(s) removed? Yes _____ No _____

    If Yes, please provide the name and address of each such doctor and the dates of those discussions:

    _____

    _____

14. Have you had discussions with any doctor or healthcare provider about whether your claimed injury(ies) is related to your receipt of the Device(s) at issue? Yes _____ No _____

    a. If Yes, identify the doctor(s) with whom you had such discussions by name and address and the dates and substance of those discussions: _____

    _____

    _____

    b. If Yes, identify any individuals who were present during the discussions by name and address and the dates of the discussion for which each individual was present: _____

    _____

    _____

15. Have you received any other treatment or testing related to your Device(s)? Yes _____ No _____

    No If Yes, please state:

Date	Facility Name	Address and Phone Number	Reason	Results

Date	Facility Name	Address and Phone Number	Reason	Results

III. PERSONAL INFORMATION

1. Name (first, middle name or initial, last): _____

2. Maiden or other names used and dates you used those names: _____

_____

3. Current address and date when you began living at this address: _____

_____

4. Identify each address at which you resided for the period from ten (10) years before your first hip surgery up to the present, the dates you resided at each and with whom you resided:

Address	Dates of Residence	Others Residing With You at this Address

5. Social Security Number: _____

6. Date and place of birth: _____

7. Sex: Female _____ Male _____

8. Current marital/domestic partnership/civil union status: _____

9. If married or in a domestic partnership/civil union, please provide the following information:

   a. Date of marriage/domestic partnership/civil union: _____

b. Name of spouse/partner: _____

c. Date and place of birth of spouse/partner: _____

d. Spouse's/partner's occupation: _____

10. If married or in a domestic partnership/civil union, has your spouse/partner filed a loss of consortium or other claim in this action? Yes _____ No _____

11. Name(s) of former spouse(s)/partner(s), dates of marriage(s)/domestic partnership(s)/civil union(s) and dates the marriage(s)/domestic partnership(s)/civil union(s) were terminated, and the nature of the termination (i.e., death, divorce): _____

_____

12. If you have children, list each child's name, date of birth and address: _____

_____

_____

13. Identify all schools you attended, including high school, college, university or other education institution:

Name of School	Address	Dates of Attendance	Degree Awarded	Major or Primary Field

14. For the period of time from ten (10) years before your first hip surgery, until the present, please identify all of your employers, with name, address and telephone number, your employment dates, your position there, and your reason for leaving:

Name of Employer	Address and Telephone Number	Dates of Employment	Describe Your Position or Duties and Specify if Job Required Manual Labor	Reason for Leaving

Name of Employer	Address and Telephone Number	Dates of Employment	Describe Your Position or Duties and Specify if Job Required Manual Labor	Reason for Leaving

15. Please identify your Driver's License Number and the issuing state and/or provide a copy of your license (if you have had driver's licenses in more than one state, list separate responses for each state):

_____

16. For the period from five (5) years before your first hip surgery until the present, please indicate your average daily activities (e.g., household chores, grocery shopping, landscaping, travel, child care, etc.)

Type of Activity	Dates/Years Engaged Activity	Approximate Number of Hours Per Week Spent on Activity

17. For the period from five (5) years before your first hip surgery until the present, please indicate if you have actively participated in any sports: Yes _____ No _____

If Yes, please state:

Type of Sport	Dates/Years Played	Approximate Number of Hours You Played Per Week	Approximate Number of Hours You Practiced Per Week

Type of Sport	Dates/Years Played	Approximate Number of Hours You Played Per Week	Approximate Number of Hours You Practiced Per Week

18. For the period from five (5) years before your first hip surgery until the present, please indicate if you have regularly exercised or taken part in other forms of physical activity: Yes _____ No _____

If Yes, please state:

Type of Exercise	Dates/Years Exercised	Approximate Number of Hours Exercised Per Week	Period of Times During Which You Performed This Exercise (month/year)

If Yes, please provide information as to any gym memberships or fitness classes attended, including name and address of each: _____

_____

19. Have you ever served in any branch of the military? Yes _____ No _____

a. Branch and dates of service: _____

b. If Yes, were you ever discharged for any reason relating to your medical, physical, psychiatric or emotional condition(s)? _____

c. If Yes, state what that condition was: _____

d. Have you ever been rejected by the military for any reason relating to your medical, physical, psychiatric or emotional condition(s)? _____

e. If Yes, state what that condition was: _____

20. Are you a Medicare recipient? Yes _____ No _____

If Yes, please specify the following:

a. State your Health Insurance Claim Number (HICN): _____

b. Provide the date on which you first began receiving such benefits: _____

_____

[Please note: If you are not currently a Medicare-eligible beneficiary, but become eligible for Medicare during the pendency of this lawsuit, you must supplement your response at that time. This information is necessary for all parties to comply with Medicare regulations. See 42 U.S.C. 1395y(b)(8), also known as Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 and 42 U.S.C. 1395y(b)(2), also known as the Medicare Secondary Payer Act.]

21. Has any insurance company or other company provided medical coverage to you (either directly or through a group including any employer of yours) or paid medical bills on your behalf at any time, beginning ten (10) years before the date of your first hip surgery to the present?

Yes _____ No _____

If Yes, then as to each company, separately state:

Name of company: _____

Address of company: _____

The Account/policy number or designation: _____

Dates of coverage: _____

When claims were made: _____

22. Have you ever been denied life insurance or medical insurance for reasons relating to your medical or physical condition(s)? Yes _____ No _____

If Yes, state the date (including month and year), the name of the company and the company's stated reason for denial: _____

23. ***(Answer this question only if you are claiming damages for mental or emotional distress in this lawsuit.)*** Have you ever been denied life insurance or medical insurance for reasons relating to your mental or emotional condition(s)? Yes _____ No _____

If Yes, state the date (including month and year), the name of the company and the company's stated

reason for denial: _____

_____

24. Have you ever been out of work for more than thirty (30) consecutive days for reasons related to your health, beginning ten (10) years before the date of your first hip surgery to the present? If yes, set forth the dates (including months and years) and the reason. Yes _____ No _____

Dates: _____

Reason(s): _____

Dates: _____

Reason(s): _____

25. Have you been on or applied for workers' compensation, social security, and/or state or federal disability benefits? Yes _____ No _____

If Yes, then as to each application, separately state the following and attach any documents you have which relate to the application and/or award of benefits:

a. Date or year of application: _____

b. Place of employment, including name, address, and telephone number, at the time of application: _____

c. Job description/duties at the time of application: _____

d. Type of benefits: _____

e. Nature of claimed injury/disability: _____

f. Period of disability: _____

g. Amount awarded: _____

h. Basis of your claim: _____

i. Was claim denied? _____

j. To what agency or company did you submit your application: _____

_____

k. Claim/docket number, if any: _____

26. Have you ever been involved in an accident or other event as a result of which you suffered any personal injuries to your legs, hips, knees or pelvic area? Yes _____ No _____

If Yes, please provide the following information and attaché copies of any accident reports:

Place and date of accident	Circumstances, Nature, Location, and Extent of Injury	Nature of Activity at Time of Injury	Names and Addresses of Treating Physician(s)

27. Have you ever filed a lawsuit or made a claim against anyone related to any bodily injuries, including but not limited to a medical malpractice lawsuit or a lawsuit against a pharmaceutical and/or medical device company? Yes _____ No _____

If Yes, please provide the following information and attach copies of all pleadings, releases or settlement agreements and deposition transcripts you have:

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

If an insurance carrier was involved in the claim(s) or complaint(s), please also provide the policy number, the claim number, the claims representative and the determination made by the insurance carrier: _____

28. Have you or your spouse/partner ever declared bankruptcy since the date of your original hip implantation surgery? Yes _____ No _____

If Yes, please state when and in what court you filed your bankruptcy petition, including the docket number of the petition and the orders of discharge: _____

_____

29. Does any third party have decision making authority over the terms of any settlement or other resolution of your claim? Yes _____ No _____

If Yes, please state:

The name and address of the third party and the basis for the third party's decision making authority over the terms of any settlement or resolution of your claim: _____

_____

30. Since you received your Device(s), have you publicly posted a comment, letter, message or blog entry on a public internet site or in a newspaper (e.g. no password required for access) in which you have discussed or described your Device(s) experience, injury, disability, pain or physical complaints related to the Device(s)? (You should include non-password protected postings on public social network sites including Twitter, Facebook, MySpace, LinkedIn or "blogs" where the general public may post Device-related comments.) Yes _____ No _____

If so, attach copies of each, or, if unavailable, please tell us where and when you made such public posts and the substance of what was posted. (Do not include postings that were provided exclusively to your attorney or your attorney's representative.)

_____

_____

IV. <u>HEALTHCARE PROVIDERS</u>

1. Identify each doctor or healthcare provider (including but not limited to family/primary care physicians, physical therapists, chiropractors, practitioners of the healing arts) whom you have seen for medical care and treatment <u>not related</u> to your legs, hips or knees for the period ten (10) years before your first hip surgery to the present.

Name and Specialty	Address and Phone Number	Approximate Dates/Years of Visits	Reason

2. Identify each hospital, clinic, surgery center, healthcare facility, physical therapy or rehabilitation centers where you have received medical treatment (in-patient, out-patient, or emergency room visit) not related to your legs, hips or knees for the period ten (10) years before your first hip surgery to the present.

Name	Address	Admission Date(s)	Reason	Type of Surgery (if Applicable)	Name of Surgeon (if Applicable)

3. Identify each doctor or healthcare provider (including but not limited to family/primary care physicians, orthopedist, orthopedic surgeon, physical therapists, chiropractors, practitioners of the healing arts) whom you have seen for medical care and treatment related to your legs, hips or knees at any time through the present.

Name and Specialty	Address and Phone Number	Approximate Dates/Years of Visits	Reason

Name and Specialty	Address and Phone Number	Approximate Dates/Years of Visits	Reason

4. Identify each hospital, clinic, surgery center, healthcare facility, physical therapy or rehabilitation centers where you have received medical treatment (in-patient, out-patient, or emergency room visit) related to your legs, hips or knees at any time through the present.

Name	Address	Admission Date(s)	Reason	Type of Surgery (if Applicable)	Name of Surgeon (if Applicable)

5. Identify each facility at which radiographs (x-rays, ultrasounds, MRIs, CT scans, bone scans) were taken of your joints, including your legs, hips or knees at any time through the present.

Name	Address and Phone Number	Approximate Date Taken	Reason

6. Identify each laboratory at which your blood was tested in the last 15 years for blood levels of any

metals including cobalt and chromium.

Name	Address and Phone Number	Approximate Date Taken	Reason	Results (if known by you)

7. Identify each laboratory at which your blood was tested from five (5) years prior to your first hip implant surgery through the present.

Name	Address and Phone Number	Approximate Date Taken	Reason	Results (if known by you)

8. Identify each pharmacy, drugstore or any other facility or supplier (including but not limited to mail order pharmacies) where you ever received any prescription medication for the period seven (7) years before your first hip surgery to the present.

Name of Pharmacy/Supplier	Address and Telephone Number of Pharmacy/Supplier	Approx. Dates/Years You Used Pharmacy/Supplier

Name of Pharmacy/Supplier	Address and Telephone Number of Pharmacy/Supplier	Approx. Dates/Years You Used Pharmacy/Supplier

V. MEDICAL BACKGROUND

1. Current Height: _____

2. Please state your weight at the following times:

   a. Current: _____

   b. Time of implant at issue: _____

   c. Time of revision surgery (if any): _____

3. Smoking History

   a. Have you ever smoked cigarettes? Yes _____ No _____

   State 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 _____

   State amount smoked/utilized: _____cigars/pipes/smokeless tobacco per day for _____ years, during the years _____ to _____.

4. For the period of time five (5) years before your first hip surgery up to the present, set forth the amount and type(s) of alcoholic beverages you consume(d) on a weekly or monthly basis on average and the type. If the amount has materially changed over this period of time, please describe/explain.

   _____

   _____

5. Have you ever experienced an allergic reaction, including to any food, medication, jewelry or metal?

   Yes _____ No _____

   If Yes, please state the following:

Type of Food, Medication, Jewelry or Metal	When Allergy Diagnosed	Symptoms of Allergy	Name & Address of Health Care Provider Who Diagnosed Allergy	Treatment Received, if any

6. ***Only if you are claiming damages for mental or emotional distress in this lawsuit as a consequence of your receipt of the Device(s)****, state whether you have experienced or been treated for any psychological, psychiatric or emotional condition prior to developing the injury(ies)/condition(s) alleged, including, but not limited to, panic attacks, anxiety, post-traumatic stress disorder, depression, thoughts of hurting yourself or other people, schizophrenia, bipolar disorder, personality disorders (e.g. obsessive compulsive disorder, paranoid, borderline, histrionic), generalized anxiety disorder, social phobia/anxiety disorder, mania, poor sleep, poor concentration, suicidal thoughts/attempts and/or drug or alcohol addiction.* Yes _____ No _____

   If Yes, state:

   a. Name and address of each healthcare provider who treated you: _____

   _____

   b. Conditions for which treated: _____

   c. Dates (including months and years) treated: _____

   d. Medications prescribed for such condition(s): _____

   _____

7. Other Conditions

   a. To the best of your knowledge or understanding, have you ever experienced or been diagnosed with any of the following conditions from the time beginning ten years before your first hip surgery to the present? 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	I Don't Know
Acetabular perforation			

Condition Experienced or Diagnosed	Yes	No	I Don't Know
Allergies, such as hay fever, asthma, eczema, hives, sensitivity to drugs or other substances, including allergic reactions to metals or minerals, including jewelry			
Aseptic Lymphocyte-Dominated Vasculitis-Associated Lesion (ALVAL)			
Any pathological condition of the acetabulum (e.g., arthrokatadysis)			
Arthritis (e.g., osteoarthritis, traumatic arthritis, rheumatoid arthritis, degenerative arthritis)			
Associated Reactions to Metal Debris (ARMD)			
Avascular necrosis			
Neck or spinal injury or medical condition			
Bone fracture			
Cancer (including blood cancers such as leukemia)			
Charcot's or Paget's disease			
Chronic Fatigue Syndrome			
Colitis or Ulcerative Colitis treated with medication			
Congenital dysplasia of the hip or subluxation or dislocation of the hip joint			
Crohn's Disease treated with medication			
Deep Vein Thrombosis (DVT)/blood clots			
Degenerative joint or disc disease			
Diabetes			
Disabilities of joints			

Condition Experienced or Diagnosed	Yes	No	I Don't Know
Drug and/or alcohol addiction			
Femoral shaft perforation, fissure or fracture			
Fibromyalgia			
Heart attack/Myocardial Infarction (MI)			
Ileitis treated with medication			
Immunodeficiency disorders			
Infections lasting longer than a week or occurring more frequently than monthly			
Inflammatory bowel disease treated with medication			
Itching (persistent lasting more than one week) treated with medication			
Joint pain lasting more than a few days			
Lupus			
Lyme Disease			
Neuromuscular compromise or vascular deficiency			
Obesity			
Osteolysis			
Periarticular calcification or ossification			
Peripheral neuropathies or nerve damage			
Poor bone quality (e.g., osteoporosis)			
Reflex Sympathetic Dystrophy Syndrome (RSDS) or Complex Regional Pain Syndrome (CRPS)			
Renal insufficiency			
Skeletal hyperostosis			

Condition Experienced or Diagnosed	Yes	No	I Don't Know
Slipped Capital Femoral Epiphysis			
Trochanteric fracture			
Tumors or Pseudo-tumors			

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

Condition You Experienced	Approx. Date of Onset	Name, Address and Phone Number of Treating Physician (if any)	Treatment Received

8. Please indicate whether you ever received any of the following treatments or diagnostic procedures and provide all information requested:

a. Joint-related, non-implant, surgeries, other than what has previously been identified above, specifying the condition(s) for which the surgery was performed:

Surgery and condition(s) for which it was performed: _____

_____

Date (month and year): _____

Treating physician and address: _____

_____

Hospital and address: _____

_____

b. Any other surgeries, from five (5) years before your first hip implant surgery to the present,

specifying the condition(s) for which the surgery was performed:

Surgery and condition(s) for which it was performed: _____

_____

Date (month and year): _____

Treating physician and address: _____

_____

Hospital and address: _____

_____

c. Other than the implantation of the Device(s) at issue, have you had implanted in your body any other medical product, not joint-related, of any kind (excluding dental fillings, crowns and bridges)? Yes _____ No _____

If Yes, please provide the following information:

Product Name: _____

Date of Procedure Placing the Device: _____

Name and Address of Implanting Physician: _____

_____

Condition Sought to be Treated: _____

Any complications encountered with device or procedure: _____

Does the device remain implanted inside of you today? Yes _____ No _____

9. Have you ever participated in any clinical trials or studies relating to any medical devices, drugs or treatments for any joint-related medical condition(s)?

_____ Yes _____ No _____ I am unaware if I have participated in any such clinical trials or studies

If Yes, please identify:

Name of trial or study: _____

Sponsor of trial or study: _____

Drug, device or treatment studied: _____

Purpose of the drug, device or treatment studied: _____

Name and address of the investigator in charge of your care and treatment in the trial or study: _____

_____

The dates (months and years) you participated in the trial or study: _____

VI. MEDICATIONS

1. List all medications (prescription and over the counter, including any vitamins) you currently take.

Medication	Dose/Frequency/ Dates of Use	Physician Ordering	Pharmacy Dispensing	Purpose

2. To the best of your recollection, list each prescription or over the counter medications (including vitamins) you have taken regularly starting from five (5) years prior to your first hip implant surgery to the present, other than those already identified above.

Medication	Dose/Frequency/ Dates of Use	Physician Ordering	Pharmacy Dispensing	Purpose

3. To the extent not already provided, list each prescription or over the counter medicine (including vitamins) you have taken during the time the Device(s) at issue was in your body.

Medication	Dose/Frequency/ Dates of Use	Physician Ordering	Pharmacy Dispensing	Purpose

4. To the best of your recollection, state whether you took or were treated with any steroids from ten (10) years prior to the date of your first hip surgery through the present. If so, provide the names of the steroids you have used, the dates (including months and years) you took the steroids, how frequently you took the steroids, the names and addresses of the doctors who prescribed the steroids and addresses of the pharmacies at which you fill the steroid prescription.

_____

_____

_____

VII. INFORMATION AS TO DEVICE(S) AT ISSUE

1. Describe the condition for which the Device(s) was(were) implanted: _____

_____

_____

2. Who diagnosed you with the condition(s) for which you received the Device(s)? Identify the healthcare provider by name and address: _____

_____

3. Did you request that any doctor or clinic implant the ABG II or REJUVENATE device:

Yes _____ No _____

If No, who suggested that you receive an ABG II or REJUVENATE device? Identify the healthcare provider or other individual by name and address: _____

_____

4. Before the implantation of the Device(s), did you receive non-surgical treatment for your hip?

   Yes _____ No _____

   a. State the period during which you received non-surgical treatment: _____

      _____

   b. State the nature of the non-surgical treatment (e.g., rest, physical therapy, medication, injections): _____

      _____

   c. State the name and address of all doctors or health care providers involved in your nonsurgical treatment: _____

      _____

5. Did you read or rely upon any documents or other information from Howmedica Osteonics Corp., which has done business as Stryker Orthopaedics, in making your decision to have the Device implanted?

   Yes _____ No _____

   If Yes, please:

   a. Identify each document/source of information:

   b. State when you read the document/received the information:

   c. State how you obtained the document or information:

   d. Do you have a copy of the document(s) in your possession? If so, please produce a copy of it together with your answers to the Plaintiff's Fact Sheet.

      Yes _____ No _____ I don't know _____

      If you no longer have the document or written information in your possession, please describe the information that you received to the best of your ability: _____

      _____

6. Did you read or rely upon any documents, brochures, DVD's or other information relating to the

Device(s) implanted prior to your surgery?

Yes _____ No _____

If Yes, please:

a. Identify each document/source of information:

b. State when you read the document/received the information:

c. State how you obtained the document or information:

d. Do you have a copy of the document(s) in your possession? If so, please produce a copy of it together with your answers to the Plaintiff's Fact Sheet.

Yes _____ No _____ I don't know _____

If you no longer have the document or written information in your possession, please describe the information that you received to the best of your ability: _____

_____

7. Were you given any verbal or written instructions, warnings or other information regarding the Device(s) and/or the implantation of the Device(s)?

Yes _____ No _____ I don't know _____

a. If Yes, when did you receive the information? _____

b. Who gave you the information? _____

c. Do you have the written information in your possession? If so, please produce a copy of it together with your answers to the Plaintiff Fact Sheet.

Yes _____ No _____ I don't know _____

d. Please describe the oral instructions/warnings you received to the best of your ability: _____

_____

8. Did you view or hear any commercials or advertisements regarding the Device(s) prior to receiving the Device(s) at issue?

Yes _____ No _____

If Yes, please state:

a. Date(s) (including month(s) and year(s)) you viewed or heard the commercial(s) or advertisement(s): _____

b. Identify the city and state in which you were located when you viewed or heard the commercial(s) or advertisement(s): _____

c. Identify each person present when you viewed or heard the commercial(s) or advertisement(s):

_____

d. Provide a summary of the commercial(s) or advertisement(s) viewed or heard and identify any spokesperson(s): _____

9. a. When did you learn that the Device had been recalled? _____

b. How did you learn about the recall? _____

c. Did you discuss the recall with any physicians? Yes _____ No _____

If yes, please identify the physician(s), the address(es), and the approximate date(s) and substance of the discussion(s).

_____

_____

d. Did you contact the Broadspire call center regarding the recall? Yes _____ No _____

If Yes, please provide the following information:

i. Did you receive a claim number? Yes _____ No _____

If Yes, what is your claim number? _____

ii. Did you receive any expense reimbursement through this process?

Yes _____ No _____

iii. Do you want to receive copies, at your expense (advanced by your attorney for the fair and ordinary costs of copying), of the medical records that Broadspire obtained about you pursuant to your authorization (if any)? Yes _____ No _____

10. Have you had any communications with any present or former employees of Howmedica Osteonics Corp., which has done business as Stryker Orthopaedics, or any Device distributor or sales

representative concerning the Device, the recall or matters in any way related to this lawsuit?

Yes _____ No _____

If Yes, for each, please state:

Date of Communication	Name of Person with Whom You Communicated	Mode of Communication (In person, by phone, email or mail)	Describe Substance of Communication (Attach copies of any documents available)

VIII. INJURIES & DAMAGES

1. Are you claiming any physical injuries or illness as a result of the Device(s)? Yes _____ No _____

   a. If yes, describe in detail all of the physical injuries or illness you claim are related to the Device(s) and indicate when the symptoms began: _____

   _____

   _____

   b. For each of the above-described injuries or illnesses that are continuing, please state your current condition and describe any ongoing limitations and/or symptoms that you claim were caused by or are related to your Device(s): _____

   _____

   c. Please identify each injury or illness you suffered either during or subsequent to the revision surgery:

      i. Debridement of Necrotic Tissue Yes _____ No _____

      ii. Unintended Femur Fracture Yes _____ No _____

      iii. Osteotomy for Stem Removal Yes _____ No _____

      iv. Placement of Cabling or Hardware for Fracture Yes _____ No _____

      v. Infection Yes _____ No _____

      vi. Complications of Anesthesia Yes _____ No _____

vii. Hip Dislocation Yes _____ No _____

viii. Bracing for Hip Dislocation Yes _____ No _____

ix. Reoperation for Complications of Revision Yes _____ No _____

x. Other: _____

d. Provide the approximate date of treatment for each condition, and identify the name and address of each healthcare provider that you have seen for these problems:

Condition You Experienced	Approx. Dates of Treatment	Name, Address and Phone Number of Healthcare Provider (if any)

e. Did you ever suffer any of the injuries or conditions identified above prior to the date of your first implant surgery? If yes, identify the date (including month and year) of diagnosis and who diagnosed the condition at that time: _____

_____

f. Do you claim that your receipt of the Device(s) worsened a condition(s) that you already had or had in the past?

Yes _____ No _____ I don't know _____

If Yes, set forth the injury(ies) or condition(s); whether you had already recovered from that injury(ies) or condition(s) before you received the Device(s); and date of recovery, if any:

_____

_____

2. Do you claim any psychological or psychiatric injury as a consequence of having the Device?

Yes _____ No _____

If Yes, please state the following as it pertains to your treatment for any psychiatric and/or psychological condition(s):

Condition	Name and Address of Mental Healthcare Provider (if any)	Approx. Dates/Years of Treatment/Visits (if any)

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

Yes _____ No _____

a. If yes, describe your claim and attach your W-2 forms for the five (5) years before your first hip implant surgery through the present. Your description should include the total amount of time (and amount of income) you have lost or will lose from work as a result of any condition that you claim or believe was caused by the Device, and an explanation of how those amounts were calculated:

_____

_____

_____

b. If you claim a loss of earnings, state your earned income from five (5) years prior to your first hip implant surgery through the present:

Year	Income

IX. MEDICAL AND OUT-OF-POCKET EXPENSES

1. State the amount of medical expenses, by provider, which you have incurred, including amounts billed to insurers and other third party payors, which are related to any condition which you claim or believe was caused by the Device(s) for which you seek recovery in this action:

Name and Address of Provider	Dates of Treatment	Amount of Medical Expenses
		$
		$
		$
		$

For any expenses claimed above, have they been reimbursed by any third party, including but not limited to Broadspire? Yes _____ No _____

If Yes, identify which expenses, the amount reimbursed and the date reimbursed: _____

_____

X. DECEASED INDIVIDUALS AND AUTOPSY INFORMATION

1. Are you filling this out on behalf of an individual who is deceased? Yes _____ No _____

   If Yes, please state the following from the Death Certificate of the individual, and attach a copy of the letter of administration:

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

   Date of death: _____

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

   Facility or location where death occurred: _____

   Name of physician who signed death certificate: _____

   Cause of death: _____

2. Are you filling this out on behalf of an individual who is deceased and on whom an autopsy was

performed? Yes _____ No _____

If Yes, please state the following from the Autopsy Report of the individual:

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

Date of autopsy: _____

Name of physician who performed autopsy: _____

XI. FACT WITNESSES

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:

Name:

Address:

Relationship to you:

XII. DOCUMENT DEMANDS

In responding to this section of the Plaintiff Fact Sheet, please use the following definition:

"Document" means any writing or record of any type, however produced an whatever the medium on which it was produced, and includes, without limitation, the original and non-identical copy (whether different from the original because of handwritten notes or underlining on the copy or otherwise) and all drafts of papers, letters, telegrams, telexes, notes, notations, memoranda of conversations or meetings, calendars, diaries or journals, minutes of meetings, interoffice communications, electronic mail, message slips, notebooks, agreements, reports, articles, books, tables, charts, schedules, memoranda, medical records, X-rays, advertisements, pictures, photographs, films, accounting books or records, billings, credit card records, electrical or magnetic recordings or tapes, or any other writings, recordings or pictures of any kind or description.

Please produce the following documents:

1. All medical records from any physician, hospital or healthcare provider who has treated you for any

injury, illness and/or disease identified in response to this Plaintiff Fact Sheet.

2. Please attach a copy of: (1) the operative report(s) for the implant of the Device(s) at issue in this case, including the product identification information/stickers where available, and, if the Plaintiff has undergone one or more revision surgeries, (2) the operative report(s) from the surgery(ies) to remove the Device(s) at issue in this case.
3. All radiographs (x-rays, ultrasounds, MRI's, CT scans) that relate to the condition and injuries alleged in Plaintiff's Complaint, show any portion of Plaintiff's hip and/or depict the Device(s).
4. All laboratory reports and results of blood tests performed on Plaintiff that show the level of cobalt and chromium ion levels in the blood.
5. All documents and/or notices received by Plaintiff with respect to third party lien holders, including but not limited to, insurance companies, workers compensation, Medicare/Medicaid and/or other governmental entities.
6. All records of any other expenses allegedly incurred as a result of the injuries alleged in the Complaint.
7. All photographs or videos of Plaintiff's surgery(ies), all photographs or videos depicting the Device(s) at issue, and all photographs and videos of Plaintiff which show Plaintiff's condition since the date of the original implantation.
8. All recordings, including but not limited to, audio recordings and video recordings, chronicling the injuries alleged in the Complaint.
9. All documents (including photographs or images) that depict the injuries, and/or damages alleged in the Complaint, including, but not limited to, any audio tapes, CDs, videotapes, DVDs, or photographs depicting any rehabilitation or treatment related to the injuries alleged in the Complaint.
10. Any documents, including but not limited to, literature or warnings received by you from surgeons, physicians, or other healthcare professionals who have treated you for any condition related to the Device(s).
11. Copies of all advertisements or promotions for the Device(s) received or reviewed before filing this

action.

12. Any documents including diaries, journals, calendars, emails, texts, letters, postings on websites, blogs and social media accounts (e.g. Facebook, MySpace, Twitter, Instagram, Vine) or other notes prepared by Plaintiff or Plaintiff's representative, other than Plaintiff's attorneys, concerning Howmedica Osteonics Corp., which has done business as Stryker Orthopaedics, the Device(s) and/or Plaintiff's physical and emotional health.
13. All documents that refer or relate to the Device(s) at issue obtained from the Food and Drug Administration or other government agencies.
14. All documents you received concerning the recall of the Device(s), whether created by Howmedica Osteonics Corp., which has done business as Stryker Orthopaedics, your healthcare provider or any other third party.
15. Decedent's death certificate, letter of administration and/or autopsy report (if applicable).
16. All bankruptcy petitions and orders of discharge (if applicable) for all bankruptcy claims made by you or your spouse since the date of your first hip surgery.
17. Documents that relate in any way to your application for, or award of, workers' compensation benefits for any injury or condition related to your hip during the period from ten years before your first hip surgery to the present.
18. Copies of any accident report(s) related to any accident or event, in which or as a result of which you suffered any personal injuries to your legs, hips or pelvic area for the ten (10) years before your first hip implant surgery to the present.
19. Copies of all pleadings, releases or settlement agreements and deposition transcripts related to any lawsuit or claim against anyone related to any injury to your hip, pelvis or legs.
20. Documentation of any agreement you have entered into, other than your retention agreement with your attorney or any lien or repayment obligations related to medical expenses, which creates an obligation to pay or repay money that is contingent on the outcome of your case.
21. Copies of any documents from Howmedica Osteonics Corp., which has done business as Stryker

Orthopaedics, that you read or relied on in making your decision to have the Device(s) implanted.

22. Copies of any written instructions, warnings or other information received from any source regarding the implantation of the Device(s), including any informed consent form.
23. Copies of any communications with any present or former Howmedica osteonics Corp., which has done business as Stryker Orthopaedics, employee, any Device distributor or sales representative concerning the Device(s) or matters in any way related to this lawsuit.
24. All documents, including but not limited to medical bills, related to the medical expenses (whether paid by you, insurers, Medicare/Medicaid or other third parties) for which you seek recovery int his lawsuit.

AUTHORIZATIONS

Complete and sign the attached Authorizations.

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 this Plaintiff Fact Sheet, 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.

Date: _____ _____

Signature