IN RE: PROPULSID® LITIGATION

THIS RELATES TO:

Civil Action No:

[plaintiff's name]

v.

[defendants' names]

MDL Docket No. 1355

PATIENT PROFILE FORM

Please provide to the best of your knowledge the following information for each individual on whose behalf a claim is being made. If you are completing this questionnaire in a representative capacity, please respond to the remaining questions with respect to the person who used Propulsid. Those questions using the term "You" refer to the person who used Propulsid. In filling out this form, please use the following definitions: (1) "health care - provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, psychiatric or psychological care or advice, and any pharmacy, weight loss center, counselor, dentist, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, therapist, nurse, herbalist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you; (2) "document" means any writing or record of every type that is in your possession, including but not limited to written documents, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phono-records, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form. You may attach as many sheets of paper as necessary to fully answer these questions.

If you are completing this questionnaire in a representative capacity (on behalf of the estate of a deceased person or a minor), please state:

1. Your name _____

2. Address _____

3. In what capacity you are representing the individual _____

4. If you were appointed by a court, state the court & date of appointment_____

5. Your relationship to deceased or represented person_____

6. If you represent a decedent's estate, state the date of death of decedent_____

I. <u>Personal Data</u>

a. Name: _____

b. Any other names used and dates of use:_____

c. Address: _____

d. Date when began living at current address: _____

e. All prior addresses during last ten years and corresponding dates:
_____
_____
_____

f. Social Security Number: _____

g. Date and place of birth: _____

h. Date of Death, if applicable: _____

i. Marital Status: _____

j. Name(s) of current and former spouse(s) and date(s) of marriage(s), if applicable:
_____

k. Name(s) and date(s) of birth of children, if applicable:

_____
_____
_____
_____
_____
_____

l. Current employer

(i) Name: _____
(ii) Address:_____
(iii) Duties:_____
(iv) Job title: _____
(v) Dates Employed:_____
(vi) Full-time or Part-time:_____
(vii) Are you making a wage loss claim? _____ Yes _____ No
If "yes," state your annual income:
(viii) Did you leave the job for a medical reason? _____ Yes _____ No
If "yes," describe why you left that job:
(ix) Name of Supervisor: _____

m. All employers (other than current employer) that you have had in the last ten years:

(i) Name: _____
(ii) Address:_____
(iii) Duties:_____
(iv) Job title: _____
(v) Dates Employed:_____
(vi) Full-time or Part-time:_____
(vii) Are you making a wage loss claim? _____ Yes _____ No
If "yes," state your annual income:
(viii) Did you leave the job for a medical reason? _____ Yes _____ No
If "yes," describe why you left that job:
(ix) Name of Supervisor: _____

n. Schools you have attended (high school and beyond only):

(i) <u>High School</u>
(a) Name:
(b) Address:
(c) Grade completed:
(d) Year graduated:

(ii) Did you attend school beyond high school? _____ Yes _____ No

If "yes," then as to each school separately state:

(a) Name:
(b) Address:
(c) Dates of attendance:
(d) Degree awarded:
(e) Major or primary field

o. Has any insurance or other company provided medical coverage to you or paid medical bills on your behalf at any time beginning ten years prior to prescription of Propulsid® to the present? _____ Yes _____ No

If "yes," then as to each Company, separately state:

(i) Name of company:
(ii) Address of company:
(iii) When company made payments:
(iv) Medical conditions for which payments were made:

p. Have you ever applied for worker's compensation social security or state or federal disability benefits?

If "Yes," then as to each application, separately state:

(i) Date (or year) of application:
(ii) Type of benefits:
(iii) Amount awarded:
(iv) Basis of your claim:
(v) If denied, reason for denial:
(vi) To what agency or company did you submit your application (e.g. Maryland Division of Social Security):

q. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury?_____

If yes, state the court in which such action was filed and the civil action or docket number assigned to each such claim, action, or suit.

_____

_____

II. **Health Care Providers**

a. For each healthcare provider whom you have seen during the last fifteen (15) years, state:

(i) Name: ____
(ii) Specialty, if any:____
(iii) Address: ____
(iv) Phone: ____
(v) Reason(s) for Visit(s): ____
____
(vi) Medications prescribed or recommended by provider: _______________________
____

(i) Name: ____
(ii) Specialty, if any:____
(iii) Address: ____
(iv) Phone: ____
(v) Reason(s) for Visit(s): ____
____
(vi) Medications prescribed or recommended by provider: _______________________
____

(i) Name: ____
(ii) Specialty, if any:____
(iii) Address: ____
(iv) Phone: ____
(v) Reason(s) for Visit(s): ____
____
(vi) Medications prescribed or recommended by provider: _______________________
____

(i) Name: ____
(ii) Specialty, if any:____
(iii) Address: ____
(iv) Phone: ____
(v) Reason(s) for Visit(s): ____
____
(vi) Medications prescribed or recommended by provider: _______________________
____

(i) Name: _____
(ii) Specialty, if any:_____
(iii) Address: _____
(iv) Phone: _____
(v) Reason(s) for Visit(s): _____
_____
(vi) Medications prescribed or recommended by provider: _____
_____

*Please attach additional pages if necessary

b. For each hospitalization that you have undergone in the last fifteen (15) years, state:
(i) Name: _____
(ii) Address:_____
(iii) Phone:_____
(iv) Reason(s) for Hospitalization(s):_____
_____
_____

(i) Name: _____
(ii) Address:_____
(iii) Phone:_____
(iv) Reason(s) for Hospitalization(s):_____
_____
_____

(i) Name: _____
(ii) Address:_____
(iii) Phone:_____
(iv) Reason(s) for Hospitalization(s):_____
_____
_____

*Please attach additional pages if necessary.

c. For each surgery you have undergone in the last fifteen (15) years, state:

(i) Name of operation:_____
(ii) Name of surgeon_____
(iii) Address of surgeon_____
(iv) Reason for surgery_____

d. Have you ever consulted a physician or a clinic facility regarding any gastrointestinal condition or disease including but not limited to heartburn, ulcers, gastroenteritis,

bleeding, pain? If yes, state:

(i) Name of doctor or facility_____
(ii) Address_____
(iii) Date_____
(iv) Diagnosis_____
(v) Treatment_____
(vi) Medications_____
(vii) Did condition resolve?_____
(viii) Current status of condition_____

e. Have you ever had any of the following tests to evaluate for cardiac/heart disease or abnormality:

(i) Electrocardiogram [EKG/ECG]_____
(ii) Cardiac Catheterization_____
(iii) Exercise Stress Test_____
(iv) Holter Monitor_____
(v) Thallium Scan_____
(vi) Echocardiogram_____
(vii) Other diagnostic test of heart, lungs or cardiopulmonary blood vessels

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If yes, please state separately for each:

(i) Type of test_____
(ii) Date administered_____
(iii) Reason for test_____
(iv) Facility name and address_____
(v) Ordering doctor_____
(vi) Results/diagnosis_____
(vii) Treatment_____

f. Have you to the best of your knowledge ever had any of the following tests to evaluate for gastrointestinal disease or abnormality:

(i) Upper GI Series_____
(ii) Barium Swallow_____
(iii) Esophagram_____
(iv) Small bowel x-ray_____
(v) Esophagoscopy_____
(vi) Endoscopy_____
(vii) Gastroscopy_____
(viii) Colonoscopy_____

(ix) Other diagnostic test or imaging of the gastrointestinal tract_____

If yes, please state separately for each:

(i) Type of test_____
(ii) Date administered_____
(iii) Reason for test_____
(iv) Facility name and address_____
(v) Ordering doctor_____
(vi) Results/diagnosis_____
(vii) Treatment_____

III. Medical Background

a. Height:_____

b. Weight_____

c. Smoking History

1. never smoked cigarettes_____

2. past smoker of cigarettes_____
date on which smoking ceased_____
Amount smoked: _____ packs per day for _____ years

3. current smoker of cigarettes_____
Amount smoked: _____ packs per day for _____ years

IV. Propulsid®

a. Have you ever taken Propulsid®? _____ Yes _____No

b. If "yes," then separately state or identify:
(i) dosage(s):
(ii) date(s) of use:
(iii) the healthcare provider(s), who prescribed Propulsid® to you:
(iv) describe separately for each medication you have identified in 3b(i):
(v) person(s) or source from which you obtained Propulsid®
(vi) reason you understood you were prescribed Propulsid®

c. Did you receive any written or oral information about Propulsid® before you took it?
_____ Yes _____ No

d. Did you receive any written or oral information about Propulsid® while you took it?
_____ Yes _____ No

If you responded "yes" to 3c and/or 3d, separately state or describe:

(i) when you received that information:
(ii) from whom you received it:
(iii) what information you received:

e. Did you receive any written information regarding Propulsid®?

_____ Yes _____ No

If yes, please attach all such documentation in your possession.

V. Injuries, Symptoms, Diagnoses, Ailments & Damages

a. Are you claiming that you have or may develop any physical condition as a result of taking Propulsid®?
_____ Yes _____ No

If "yes," then for each such condition, separately state:
(i) Nature of condition;
(ii) The date you first became aware of it;
(iii) How you first became aware of it;
(iv) Whether (and if so, how) it has changed over time;
(v) For each such condition, have you consulted with healthcare provider(s)?
_____ Yes _____ No

If "yes" to subpart (v) then, as to each healthcare provider, state:
(A) the healthcare provider's name;
(B) the healthcare provider's address;
(C) the date of first consultation with that healthcare provider;
(D) date of last consultation;
(E) do you plan to continue to consult with that healthcare provider?
_____Yes_____No

b. Has any healthcare provider told you, orally or in writing, that any of these conditions are due to your use of any of Propulsid®?
_____Yes _____ No

If "yes," then state and describe:
(i) what you were told;
(ii) who told you and when;

c. Are you claiming that you have paid or will have to pay any expenses as a result of having taken Propulsid®?
_____Yes _____No

If "yes," then for each item separately identify:
(i) for what:
(ii) amount of fees or expenses:
(iii) person or company paid or to be paid.

d. Other than those previously identified, are you claiming that you have suffered any other injuries or damages (including any alleged mental, emotional, psychological or psychiatric injuries or damages) as a result of taking Propulsid®?
_____ Yes _____ No

If "yes," then for each such condition, separately state:
(i) Nature of condition;
(ii) The date you first became aware of it;
(iii) How you first became aware of it;
(iv) Whether (and if so, how) it has changed over time;
(v) For each such condition, have you consulted with healthcare provider(s)?
_____ Yes _____ No

If "yes" to subpart (d) then, as to each healthcare provider, state:
(A) the healthcare provider's name;
(B) the healthcare provider's address;
(C) the date of first consultation with that healthcare provider;
(D) date of last consultation;
(E) do you plan to continue to consult with that healthcare provider?
_____Yes_____No

VI. Other Medications, Supplements, Or Drugs

Indicate to the best of your knowledge whether you ever took the medication during a time when you were taking Propulsid. If yes, please indicate dates taken and prescribing doctor under comments section.

	YES	NO	IF YES, DATES TAKEN, PRESCRIBING DOCTOR	NAME AND ADDRESS OF PHARMACY WHERE OBTAINED
ANTI-INFECTIVE DRUGS:				
Biaxin [Clarithromycin]	____	____	_____	_____
Cipro [Ciprofloxaxin]	____	____	_____	_____
Crixivan [Indinavir]	____	____	_____	_____
Diflucan [Fluconazole]	____	____	_____	_____
Erythrocin & others [Erythromycin]	____	____	_____	_____

Flagyl [Metronidazole]	____	____	_____	_____
Keflex [Cephalexin]	____	____	_____	_____
Nizoral [Ketoconazole]	____	____	_____	_____
Norvir [Ritonavir]	____	____	_____	_____
Sporanox [Itraconazole]	____	____	_____	_____
TAO [Troleandomycin]	____	____	_____	_____
Zagam [Sparfloxacin]	____	____	_____	_____

ANTIDEPRESSANTS:

Adapin, Sinequan [Doxepin]	____	____	_____	_____
Elavil [Amitriptylene]	____	____	_____	_____
Lithobid, Eskalith [Lithium]	____	____	_____	_____
Ludiomil [Maprotilene]	____	____	_____	_____
Norpramin [Desipramine]	____	____	_____	_____
Pamelor [Nortriptylene]	____	____	_____	_____
Prozac [Fluoxetine]	____	____	_____	_____
Remeron [Mirtazapine]	____	____	_____	_____
Serzone [Nefazadone]	____	____	_____	_____
Tofranil [Imipramine]	____	____	_____	_____

CARDIOVASCULAR DRUGS:

Adalat [Nifedipine]	____	____	_____	_____
Betapace [Sotalol]	____	____	_____	_____
Cardiazem [Diltiazem]	____	____	_____	_____
Cordarone [Amiodarone]	____	____	_____	_____
Dyazide [HCTZ/Triamterene]	____	____	_____	_____
Hydrodiuril [Hydrochlorothiazide]	____	____	_____	_____
Inderal [Propranalol]	____	____	_____	_____
Lanoxin [Digoxin]	____	____	_____	_____
Lasix [Furosemide]	____	____	_____	_____
Norpace [Disopyramide]	____	____	_____	_____
Pronestyl [Procainamide]	____	____	_____	_____
Quinidex [Quinidine]	____	____	_____	_____
Tenormin [Atenolol]	____	____	_____	_____
Vascor [Bepridil]	____	____	_____	_____

CENTRAL NERVOUS SYSTEM DEPRESSANTS:

Compazine [Prochlorperazine]	____	____	_____	_____
Haldol [Haloperidol]	____	____	_____	_____
Mellaril [Thioridazine]	____	____	_____	_____
Serdolect [Sertindole]	____	____	_____	_____
Thorazine [Chlorpromazine]	____	____	_____	_____
Triavil, Trilfon [Perphenazine]	____	____	_____	_____

OTHER:

Hismanal [Astemizole]	____	____	_____	_____
Luvox [Fluvoxamine]	____	____	_____	_____
Mevacor [Lovastatin]	____	____	_____	_____
Terodilene	____	____	_____	_____

VII. Family History

1. To the best of your knowledge did any child, parent, sibling, aunt, uncle, or grandparent of yours suffer from any type of heart disease including but not limited to: abnormal rhythm, arteriosclerosis (hardening of the arteries), murmur, coronary artery disease, congestive heart failure, enlarged heart, leaking valves or prolapse, heart block, congenital heart abnormality, Scarlet Fever, Rheumatic Fever, atrial fibrillation?
   yes_____ no_____

2. If yes, then state separately for each:
   relative's name_____
   relationship to you_____
   type of heart problem_____
   date and cause of death if applicable_____

3. For infants and young children: was Propulsid® used during a period of time while the child was being breastfed? Yes ____ No ____ . If yes, please answer questions II and VI for the nursing mother limited to the period of time that the child was both breast fed and taking Propulsid®.

VIII. Authorizations

Complete and sign the attached Authorization for Release of Hospital, Medical and Pharmacy Records. If you are making a wage loss claim, then sign the attached Authorization for release of employment records.

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.

I verify under oath that the above responses are true and correct to the best of my knowledge.

Date:_____ _____

Signature