IN RE: REGLAN LITIGATION	SUPERIOR COURT OF NEW JERSEY LAW DIVISION: ATLANTIC COUNTY CASE NO. 289 MASTER DOCKET: ATL-L-3865-10 CIVIL ACTION **PLAINTIFF FACT SHEET**

PLAINTIFF FACT SHEET

PLAINTIFF'S NAME: _____

Plaintiff's Attorney (include email address):_____

_____

By Order of the Court and agreement of the Parties, you are required to answer each and every question set forth in this document to the best of your knowledge; no question is to be left blank. To the extent that you do not know or cannot remember the answer to a given question, you must state that in your response to the question. Similarly, to the extent a question does not apply to your claim, you must state that in your response to the question. If the space provided does not allow for a complete answer, please attach additional sheets so that your answer to each question is complete.

Please note that your answers to each question set out in this Fact Sheet constitute answers to written interrogatories pursuant to the New Jersey Rules of Court. In that respect, when completing this Fact Sheet you will be under an oath to tell the truth, and the information you provide must be true and accurate to the best of your knowledge. Further, pursuant to the New Jersey Rules of Court, you must supplement your responses to the questions set forth in this Fact Sheet if you, at any time, learn that any of your responses are incomplete or inaccurate in any respect.

I. CASE INFORMATION

A. **Please state the following for the lawsuit that you filed:**

Case caption and number: _____

Court in which action is pending: _____

Your name: _____

Social Security Number: _____

Current street address: _____

City: _____ State: _____ Zip: _____

How long have you lived at this address? _____

Have you ever lived in the State of New Jersey? Yes: ____ No: ____

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

The name of the person you are representing: _____

If you were appointed by a court, state the:

State, Court Term, and Case Number: _____

Date of Appointment: _____

Your relationship to the represented person: _____

If you represent a decedent's estate, state the date of death of the decedent and the address of the place where the decedent died: _____

NOTE: If you are completing this questionnaire in a representative capacity, please respond to the remaining questions with respect to the person who ingested Reglan® and/or metoclopramide. Those questions using the term "You" refer to the person who ingested Reglan® and/or metoclopramide. If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.

II. CLAIM INFORMATION

A. Reglan® and/or Metoclopramide Ingestion – Identify by name, specialty, and address the physician(s) who prescribed Reglan® and/or metoclopramide for you.

1. Prescribing Physician(s):

Name: _____

Specialty: _____

Address: _____

_____

Phone: _____

Conditions treated by this Physician: _____

Name: _____

Specialty: _____

Address: _____

_____

Phone: _____

Conditions treated by this Physician: _____

Name: _____

Specialty: _____

Address: _____

_____

Phone: _____

Conditions treated by this Physician: _____

2. For what condition(s) were you prescribed Reglan® and/or metoclopramide (*e.g.*, acid reflux, G.E.R.D., diabetic gastroparesis, nausea, etc.)? _____

B. Product Identification - Identify by complete brand name and/or trade name the metoclopramide product(s) you claim caused your injuries, including the formulation of each product, manufacturer of the medication(s), the NDC code(s) for each product, a description of each product, date(s) of ingestion of each product, and the pharmacy at which each product was filled.

Product	**Manufacturer**	**NDC No.** (Unknown and See attached Pharmacy Records are acceptable responses)	**Description** (e.g. tablet, syrup, IV)	**Date(s) of Ingestion**	**Pharmacy** (include address)

C. Did you ever ingest Reglan®/metoclopramide in the State of New Jersey? Yes: ____ No: ____ Cannot Recall/Unknown: _____

D. Do you claim that you suffer or suffered any physical, mental, emotional, or psychiatric illnesses or disabilities that you believe were caused by Reglan® and/or metoclopramide? Yes: ____ No: ____

If yes, for each injury, please provide the following information:

1. Describe the nature of your injury, illness or disability: _____
_____
_____

2. When, and in what city and state, did you first experience any symptoms you believe are related to the injury/ies alleged in your lawsuit? _____

_____

3. Were there any witnesses to the symptoms you identified above in question 2? Yes: ____ No: ____ Cannot Recall/Unknown: _____

If yes, state their name(s), address(es), phone number(s), and the person's relationship to you. _____
_____
_____
_____

4. Date(s) of diagnosis of the injury: _____

5. Physician by whom first diagnosed: _____

   a. Address: _____

6. Treating Physician: _____

   a. Address: _____

7. Does the injury, illness, or disability persist today? Yes: ____ No: ____

   If yes, identify the current symptoms, the treatment you continue to receive, and the physician(s) providing treatment:

   a. Current symptoms: _____

   b. Treating physician(s): _____

c. Address (if not otherwise provided): _____

_____

(Please copy and complete and attach additional pages if necessary to provide a complete response.)

If no, state how and when the injury subsided: _____
_____

E. Have you had any discussions with any medical provider(s) about whether your condition is related to your ingestion of Reglan® and/or metoclopramide?

Yes: ____ No: ____ Cannot Recall/Unknown: _____

If yes, please identify:

Name of physician: _____

Address: _____

Specialty: _____

Date of discussion: _____

and, check one of the following (only have to answer 6 if 1-5 are not applicable):

1. _____ I was told my condition is related to my ingestion of Reglan® and/or metoclopramide.

2. _____ I was told my condition is not related to my ingestion of Reglan® and/or metoclopramide.

3. _____ I was told my condition may be related to the ingestion of Reglan® and/or metoclopramide.

4. _____ I was told by the physician that he/she does not know whether my condition is related to my ingestion of Reglan®/metoclopramide.

5. _____ I don't recall what I was told.

6. _____ Other (describe discussion regarding your injury and Reglan® and/or metoclopramide): _____
_____
_____

(if discussed with more than one medical professional, please copy and complete this section for each)

F. Medical Expenses - Have you paid or incurred any medical expenses, including amounts billed or paid by insurers and other third-party payors, which are related to any condition which you claim was caused by Reglan® and/or metoclopramide for which you seek recovery in the action which you have filed?

Yes: ____ No: ____ Cannot Recall/Unknown: _____

If yes, please provide the best estimate of the total amount of such expenses at this time:

$ _____

To the extent any medical expenses have been paid by an insurance company(ies), please provide the following:

Physician (include address)	**Amount Paid (and Amount Billed)**

G. Fact Witnesses - Please identify the following for each individual likely to have discoverable information that you may use to support your claims (exclusive of experts and health care professional identified in this Fact Sheet).

1. Name: _____

Address: _____

City: _____ State: _____ Zip:_____ Phone: _____

Relationship: _____

Information they possess: _____

_____

2. Name: _____

Address: _____

City: _____ State: _____ Zip:_____ Phone: _____

Relationship: _____

Information they possess: _____

_____

3. Name: _____

Address: _____

City: _____ State: _____ Zip:_____ Phone: _____

Relationship: _____

Information they possess: _____

_____

(Please copy and complete and attach additional pages if necessary to provide a complete response.)

III. PERSONAL INFORMATION OF REGLAN® AND/OR METOCLOPRAMIDE USER

A. Background Information:

1. Name: _____

2. Maiden or other names used or by which you have been known: _____

_____

3. Identify each address at which you have resided 3 years prior to first ingestion (first date disclosed in Section II.B.) to present, and list when you started and stopped living at each one:

ADDRESS	DATES OF RESIDENCE

4. Date of Birth: _____

5. Place of Birth: _____

6. Sex: Male ____ Female ____

7. Have you ever had a driver's license? Yes: ____ No: ____

8. Has your driver's license ever been revoked or limited because of your health or physical condition? Yes: ____ No: ____

   If so, when, and for what reason(s): _____

9. Have you ever served in any branch of the military? Yes: ____ No: ____

   a. Branch and dates of service: _____

   b. Were you discharged for any reason relating to your health or physical condition? Yes: ____ No: ____

   If yes, state what that condition was: _____

10. Have you ever been rejected from military service for any reason relating to your health or physical condition? Yes: ____ No: ____

11. Have you ever filed a worker's compensation claim? Yes: ____ No: ____

    If yes, please state:

    a. Year claim was filed: _____

    b. Where claim was filed: _____

    c. Claim/docket number, if applicable: _____

    d. Nature of claimed injury: _____

    e. Period of disability: _____

(attach additional sheets as necessary to describe more than one claim)

12. Have you ever made a social security disability claim? Yes: ____ No: ____

If yes, please state:

a. Year claim was filed: _____

b. Where claim was filed: _____

c. Nature of disability: _____

d. Period of disability: _____

(attach additional sheets as necessary to describe more than one claim)

13. Have you ever made any other type of disability claim? Yes: ____ No: ____

If yes, please state:

a. Year claim was filed: _____

b. Where claim was filed: _____

c. Nature of disability: _____

d. Period of disability: _____

(attach additional sheets as necessary to describe more than one claim)

14. Has Medicare ever paid for any of your medical treatment?

Yes: ____ No: ____ Cannot Recall/Unknown: _____

If yes, please state:

a. List any liens placed upon you by Medicare for this treatment: _____

_____

15. Are you aware of any other liens, besides Medicare, placed upon you?

Yes: ____ No: ____

If so, when, and for what reason(s): _____

_____

16. Have you ever been denied life insurance for reasons relating to your health? Yes: ____ No: ____

If yes, please state when, the name of the company and the company's stated reason for denial. _____

_____

17. Have you ever filed a lawsuit or made a claim, other than in the present suit, seeking damages for personal injury or medical malpractice? Yes: ____ No: ____

If yes, state the state and county in which the claim was filed, the caption, case name, and/or names of adverse parties, the civil action or docket number assigned to each such claim, action, or suit, and the outcome of each such claim, action, or suit. _____

_____

18. Have you or your spouse ever filed for bankruptcy? Yes: ____ No: ____

If so, please state date filed, jurisdiction, and case identification number:

_____

19. Have you been convicted of, or pled guilty to, a crime in the last 10 years, or a felony or crime of moral turpitude ever?

Yes: ____ No: ____

If yes, describe the crime or offense, the state and county in which convicted/pled guilty, and the outcome of the charge. _____

_____

20. Have you had internet access at any time during the last 10 years?

If yes, then answer the following:

a. Did you ever visit any website containing information regarding Reglan® and/or metoclopramide and/or any of your claimed injuries?

Yes: ____ No: ____ Cannot Recall/Unknown: _____

b. Did you ever visit any social networking sites (such as Facebook) and communicate about Reglan® and/or metoclopramide and/or any of your claimed injuries?

Yes: ____ No: ____ Cannot Recall/Unknown: _____

If yes, identify the account or accounts you used to make such communications. _____

_____

_____

c. Did you ever communicate have email or chat room regarding Reglan® and/or metoclopramide and/or any of your claimed injuries?

Yes: ____ No: ____ Cannot Recall/Unknown: _____

If yes, identify the email address or addresses you used to make such communications. _____

_____

_____

B. Family Information:

1. Have you ever been married? Yes: ____ No: ____

2. If you have been married, for each spouse, state:

a. Spouse's name: _____

b. Dates of marriage(s): _____

c. Date of end of marriage: _____

d. Reason for end of marriage: _____

e. Spouse's date of birth: _____

f. Spouse's occupation: _____

3. Has your spouse filed a loss of consortium or other claim in this lawsuit? Yes: ____ No: ____

4. Please provide the following information for your parents and siblings:

Name	Relationship

5. Please indicate whether, to the best of your knowledge, your ***parents and siblings*** have experienced, been diagnosed with, or treated for any of the following conditions:

Tardive Dyskinesia	Yes: ____	No: ____	Unknown ____
Dystonia	Yes: ____	No: ____	Unknown ____
Chorea	Yes: ____	No: ____	Unknown ____
Myoclonus	Yes: ____	No: ____	Unknown ____
Akathisia	Yes: ____	No: ____	Unknown ____
Tremors	Yes: ____	No: ____	Unknown ____
Movement Disorders	Yes: ____	No: ____	Unknown ____
Tourette's Syndrome	Yes: ____	No: ____	Unknown ____
Neuroleptic Malignant Syndrome	Yes: ____	No: ____	Unknown ____
Parkinson's Disease	Yes: ____	No: ____	Unknown ____
Huntington's Disease	Yes: ____	No: ____	Unknown ____
Schizophrenia	Yes: ____	No: ____	Unknown ____
Psychosis	Yes: ____	No: ____	Unknown ____
Bipolar Disorder	Yes: ____	No: ____	Unknown ____
Restless Leg Syndrome	Yes: ____	No: ____	Unknown ____
Wilson's Disease	Yes: ____	No: ____	Unknown ____
Stiff Persons Syndrome	Yes: ____	No: ____	Unknown ____
Acute Dystonic Reaction	Yes: ____	No: ____	Unknown ____
Blepharospasm	Yes: ____	No: ____	Unknown ____
Acid Reflux	Yes: ____	No: ____	Unknown ____
GERD (gastroesophageal reflux disease)	Yes: ____	No: ____	Unknown ____
Barrett's Esophagus	Yes: ____	No: ____	Unknown ____

Gastroparesis/diabetic gastroparesis	Yes: ____	No: ____	Unknown ____
Esophageal Cancer	Yes: ____	No: ____	Unknown ____
Dementia	Yes: ____	No: ____	Unknown ____
Alzheimer's	Yes: ____	No: ____	Unknown ____
Tic	Yes: ____	No: ____	Unknown ____
Heartburn	Yes: ____	No: ____	Unknown ____
Any type of unusual or uncontrolled movements	Yes: ____	No: ____	Unknown ____
Any type of upper gastrointestinal problem	Yes: ____	No: ____	Unknown ____
Seizures	Yes: ____	No: ____	Unknown ____

C. Educational History:

1. Identify each high school, vocational school, college, university or other post-secondary educational institution you have attended, the dates of attendance, and diplomas or degrees awarded:

School or Educational Institution (provide address)	Dates of Attendance	Diploma/Degree Awarded

D. Employment History:

1. Occupation: _____

2. Current or last employer: _____

3. Employer's Address: _____

_____

4. Dates of Employment: _____

5. Complete the following information with respect to your employment the 5 years prior to first ingestion (first date disclosed in Section II.B.) to the present. Identify each employer, including the dates of each such employment and positions held:

Employer	Address	Type of Business/Position	Dates of Employment	Salary	Employee health benefits? (Yes or No)

6. Have you ever been out of work for more than thirty (30) days for reasons related to your health? Yes: ____ No: ____

If yes, please state the dates, employer, and health condition. _____

_____

E. Lost Earnings:

1. Do you claim or expect to claim that you will lose future earnings as a result of any condition that you believe was caused by Reglan® and/or metoclopramide? Yes: ____ No: ____

2. Do you claim or expect to claim that you lost earnings or suffered impairment of earning capacity as a result of any condition that you believe was caused by Reglan® and/or metoclopramide? Yes: ____ No: ____

If no, please proceed to Section IV.

3. Give your best estimate of time or wage you have lost from work as a result of any condition you claim was caused by Reglan® and/or metoclopramide and the amount of income which you lost: _____

_____

_____

IV. LIST OF HEALTHCARE PROVIDERS

A. Please give the following information for each of your physicians (including, but not limited to, primary care physicians, neurologists, gastroenterologists, dentists/dental professionals, etc.) for the 5 years prior to your first ingestion (first date disclosed in Section II.B.) to the present:

Name: _____

Dates of Service: _____

Specialty (if known): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Reason for Treatment: _____

_____

Name: _____

Dates of Service: _____

Specialty (if known): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Reason for Treatment: _____

Name: _____

Dates of Service: _____

Specialty (if known): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Reason for Treatment: _____

_____

Name: _____

Dates of Service: _____

Specialty (if known): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Reason for Treatment: _____

_____

(Please attach additional pages to provide a complete response.)

B. Health Insurance Providers - Identify each company or carrier that has provided your health insurance coverage for the 5 years prior to your first ingestion (first date disclosed in Section II.B.) to the present:

Name: _____

Dates of Service: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Name: _____

Dates of Service: _____

Specialty (if known): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Name: _____

Dates of Service: _____

Specialty (if known): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

(Please copy and complete and attach additional pages, if necessary to provide a complete response.)

C. Hospitalizations - Identify each hospital, clinic, or healthcare facility where you have received treatment for the 5 years prior to your first ingestion (first date disclosed in Section II.B.) to the present:

1. Name: _____ Approximate dates: _____

Reason for treatment: _____

Street address: _____

City: _____ State: _____ Zip:_____

2. Name: _____ Approximate dates: _____

Reason for treatment: _____

Street address: _____

City: _____ State: _____ Zip:_____

(Please copy and complete and attach additional pages, if necessary to provide a complete response.)

D. Pharmacy - Identify each pharmacy, drugstore and/or other supplier (including mail order) where you have had prescriptions filled or from which you have ever received any prescription medication for the 5 years prior to your first ingestion (first date disclosed in Section II.B.) to the present:

1. Name: _____

Street address: _____

City: _____ State: _____ Zip: _____

2. Name: _____

Street address: _____

City: _____ State: _____ Zip: _____

(Please copy and complete and attach additional pages, if necessary to provide a complete response.)

V. MEDICAL BACKGROUND

A. Do you currently suffer from any physical injuries, illnesses, or disabilities other than those that you believe were caused by Reglan® and/or metoclopramide? Yes: ____ No: ____

If yes, identify the injury, illness, or disability, symptoms, date(s) of onset and date(s) of diagnosis, by whom the condition was first diagnosed, any treatment received for the condition, and treating physician: _____

_____

_____

_____

_____

B. Height and weight on the date of your alleged injury: _____

C. Current height and weight: _____

D. Height and weight when first prescribed Reglan® or metoclopramide (as disclosed in Section II.B): _____

E. Please indicate whether, to the best of your knowledge, you have ever experienced, been diagnosed with, or treated for the following conditions PRIOR to your use of Reglan®/metoclopramide:

1. Health conditions, including but not limited to:

Tardive Dyskinesia	Yes: ____	No: ____	Unknown ____
Dystonia	Yes: ____	No: ____	Unknown ____
Chorea	Yes: ____	No: ____	Unknown ____
Myoclonus	Yes: ____	No: ____	Unknown ____
Akathisia	Yes: ____	No: ____	Unknown ____
Tremors	Yes: ____	No: ____	Unknown ____
Movement Disorders	Yes: ____	No: ____	Unknown ____
Tourette's Syndrome	Yes: ____	No: ____	Unknown ____
Neuroleptic Malignant Syndrome	Yes: ____	No: ____	Unknown ____
Stroke	Yes: ____	No: ____	Unknown ____
Parkinson's Disease	Yes: ____	No: ____	Unknown ____
Huntington's Disease	Yes: ____	No: ____	Unknown ____

Diabetes	Yes: ____	No: ____	Unknown ____
Alcoholism	Yes: ____	No: ____	Unknown ____
Head trauma	Yes: ____	No: ____	Unknown ____
Schizophrenia	Yes: ____	No: ____	Unknown ____
Psychosis	Yes: ____	No: ____	Unknown ____
Mental Illness	Yes: ____	No: ____	Unknown ____
Bipolar Disorder	Yes: ____	No: ____	Unknown ____
Depression	Yes: ____	No: ____	Unknown ____
Anxiety Disorder	Yes: ____	No: ____	Unknown ____
Mood Disorder	Yes: ____	No: ____	Unknown ____
Hallucinations	Yes: ____	No: ____	Unknown ____
Suicidal Ideation	Yes: ____	No: ____	Unknown ____
Restless Leg Syndrome	Yes: ____	No: ____	Unknown ____
Wilson's Disease	Yes: ____	No: ____	Unknown ____
Stiff Persons Syndrome	Yes: ____	No: ____	Unknown ____
Acute Dystonic Reaction	Yes: ____	No: ____	Unknown ____
Blepharospasm	Yes: ____	No: ____	Unknown ____
Acid Reflux	Yes: ____	No: ____	Unknown ____
GERD (gastroesophageal reflux disease)	Yes: ____	No: ____	Unknown ____
Barrett's Esophagus	Yes: ____	No: ____	Unknown ____
Gastroparesis/diabetic gastroparesis	Yes: ____	No: ____	Unknown ____
Esophageal Cancer	Yes: ____	No: ____	Unknown ____
Cerebrovascular disease	Yes: ____	No: ____	Unknown ____
Dementia	Yes: ____	No: ____	Unknown ____
Alzheimer's	Yes: ____	No: ____	Unknown ____
Tic	Yes: ____	No: ____	Unknown ____
Heartburn	Yes: ____	No: ____	Unknown ____
Any type of unusual or uncontrolled movements	Yes: ____	No: ____	Unknown ____
Any type of upper gastrointestinal problem	Yes: ____	No: ____	Unknown ____
Head injury	Yes: ____	No: ____	Unknown ____
Seizures	Yes: ____	No: ____	Unknown ____

If you answered "Yes" to any of the above, for each condition, identify the specific condition(s)/disorder(s), symptoms, date(s) of onset, and date(s) of diagnosis:

Specific condition/disorder: _____

Symptoms: _____

Date(s) of onset: _____

Date(s) of diagnosis: _____

Diagnosis Physician: _____

Address (if not otherwise provided): _____

Treating Physician: _____

Address (if not otherwise provided): _____

Medication and/or Treatment: _____

Current Status of Condition: _____

(Please copy and complete and attach additional pages, if necessary to provide a complete response.)

F. Drinking History:

1. Have you ever consumed alcohol (beer/wine/whiskey/etc.)?
Yes: ____ No: ____

If yes, check which represents your typical alcohol consumption during adulthood:

_____ Daily

_____ Weekly

_____ Monthly

_____ Other (explain: _____)

G. Smoking History:

1. Have you ever smoked cigarettes? Yes: ____ No: ____

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

2. Have you ever smoked cigars or pipe tobacco? Yes: ____ No: ____

If yes, state the product smoked: _____ and amount smoked: _____ for _____ years during the years _____.

H. Drug Use History:

1. Please indicate whether you have ever used the following:

Stimulants Yes: ____ No: ____ Unknown ____

Attention deficit medications Yes: ____ No: ____ Unknown ____
Antipsychotic medications Yes: ____ No: ____ Unknown ____
Tranquilizers Yes: ____ No: ____ Unknown ____
Amisulpride (Solian®) Yes: ____ No: ____ Unknown ____
Amitriptyline Yes: ____ No: ____ Unknown ____
(Elavil®, Endep®, Limbitrol®, Chlordiazepoxide)
Amoxapine (Asendin®) Yes: ____ No: ____ Unknown ____
Anticholinergics Yes: ____ No: ____ Unknown ____
Aripiprazole (Abilify®) Yes: ____ No: ____ Unknown ____
Asenapine (Saphris®) Yes: ____ No: ____ Unknown ____
Bupropion (Wellbutrin®) Yes: ____ No: ____ Unknown ____
Bupropion Hydrobromide Yes: ____ No: ____ Unknown ____
(Aplenzin®)
Buspirone (Buspar®) Yes: ____ No: ____ Unknown ____
Chlorpromazine (Thorazine®) Yes: ____ No: ____ Unknown ____
Chlorprothixene (Taractan®) Yes: ____ No: ____ Unknown ____
Cimetidine (Tagamet®) Yes: ____ No: ____ Unknown ____
Cisapride (Propulsid®) Yes: ____ No: ____ Unknown ____
Citalopram (Celexa®) Yes: ____ No: ____ Unknown ____
Clozapine (Clozaril®) Yes: ____ No: ____ Unknown ____
Cocaine Yes: ____ No: ____ Unknown ____
Crack cocaine Yes: ____ No: ____ Unknown ____
Desipramine (Norpramin®) Yes: ____ No: ____ Unknown ____
Desvenlafaxin (Pristiq®) Yes: ____ No: ____ Unknown ____
Diphenhydramine (*e.g.*, Benadryl®) Yes: ____ No: ____ Unknown ____
Droperidol (Inapsine®) Yes: ____ No: ____ Unknown ____
Duloxetine (Cymbalta®) Yes: ____ No: ____ Unknown ____
Escitalopram (Lexapro®) Yes: ____ No: ____ Unknown ____
Fluphenazine (Prolixin®) Yes: ____ No: ____ Unknown ____
Fluoroquinolones (*e.g.*, ofloxacin) Yes: ____ No: ____ Unknown ____
Haloperidol (Haldol) Yes: ____ No: ____ Unknown ____
Heroin Yes: ____ No: ____ Unknown ____
Iloperidone (Fanapt®) Yes: ____ No: ____ Unknown ____
Isocarboxazid (Marplan®) Yes: ____ No: ____ Unknown ____
LSD Yes: ____ No: ____ Unknown ____
Lithium Yes: ____ No: ____ Unknown ____
(Cibalith-S Syrup, Eskalith®, Lithane®, Lithobid®)
Lorazepam (Ativan®) Yes: ____ No: ____ Unknown ____
Loxapine (Loxitane®) Yes: ____ No: ____ Unknown ____
Maprotiline (Ludiomil®) Yes: ____ No: ____ Unknown ____
Mesoridazine (Serentil®) Yes: ____ No: ____ Unknown ____
Mirtazapine (Remeron®) Yes: ____ No: ____ Unknown ____
Molindone (Moban®) Yes: ____ No: ____ Unknown ____
Marijuana or hashish Yes: ____ No: ____ Unknown ____
Ecstasy or MDMA Yes: ____ No: ____ Unknown ____
Methadone Yes: ____ No: ____ Unknown ____

Methamphetamine or "Ice" Yes: ____ No: ____ Unknown ____
Nortriptyline (Pamelor®) Yes: ____ No: ____ Unknown ____
Olanzapine (Zyprexa, Symbax®) Yes: ____ No: ____ Unknown ____
Paliperidone (Invega®) Yes: ____ No: ____ Unknown ____
Paroxetine (Paxil®) Yes: ____ No: ____ Unknown ____
PCP Yes: ____ No: ____ Unknown ____
Perphenazine Yes: ____ No: ____ Unknown ____
(Etrafon®, Trilafon®, Amitriptylin, Triavil®)
Phenelzine (Nardil®) Yes: ____ No: ____ Unknown ____
Phenytoin (Dilantin®) Yes: ____ No: ____ Unknown ____
Pimozide (Orap®) Yes: ____ No: ____ Unknown ____
Prochlorperazine (Compazine®) Yes: ____ No: ____ Unknown ____
Promethazine (Phenergan®) Yes: ____ No: ____ Unknown ____
Protriptyline (Vicatil®) Yes: ____ No: ____ Unknown ____
Quetiapine (Serzone®, Seroquel®) Yes: ____ No: ____ Unknown ____
Risperidone (Risperdal®) Yes: ____ No: ____ Unknown ____
Selegiline Transdermal System Yes: ____ No: ____ Unknown ____
(Emsam®)
Sertraline (Zoloft®) Yes: ____ No: ____ Unknown ____
Thioridazine (Mellaril®) Yes: ____ No: ____ Unknown ____
Thiothixene (Navane®) Yes: ____ No: ____ Unknown ____
Tranylcypromine (Parnate®) Yes: ____ No: ____ Unknown ____
Trazodone (Desyrel®) Yes: ____ No: ____ Unknown ____
Trifluoperazine (Stelazine®) Yes: ____ No: ____ Unknown ____
Triflupromazine (Vesprin®) Yes: ____ No: ____ Unknown ____
Trimipramine (Surmontil®) Yes: ____ No: ____ Unknown ____
Venlafaxine (Effexor®) Yes: ____ No: ____ Unknown ____
Ziprasidone (Geodon®) Yes: ____ No: ____ Unknown ____
Amphetamines Yes: ____ No: ____ Unknown ____
Inhaled non-prescription substances Yes: ____ No: ____ Unknown ____
(*e.g.*, glue, paint, or solvents)
Caffeine-containing stimulants Yes: ____ No: ____ Unknown ____
(*e.g.*, No-Doz, Vivarin)
Sleep medications Yes: ____ No: ____ Unknown ____
Antidepressants, Cyclic Yes: ____ No: ____ Unknown ____
(*e.g.*, doxepin, imipramine, Adapin, Sinequan®, Tofranil®)
Antidepressants, SSRI Yes: ____ No: ____ Unknown ____
(*e.g.*, fluoxetine, Prozac®, Symbax®)
Tricyclic antidepressants Yes: ____ No: ____ Unknown ____
Over the counter appetite
suppressants Yes: ____ No: ____ Unknown ____
Prescription appetite suppressants Yes: ____ No: ____ Unknown ____
Dietary supplements Yes: ____ No: ____ Unknown ____
Herbal products Yes: ____ No: ____ Unknown ____
Steroids Yes: ____ No: ____ Unknown ____

If you answered "Yes" to any of the above, to the extent a response is applicable, specify:

The product(s): _____

Dates of ingestion(s): _____

Dosage of each ingestion: _____

Prescriber: _____

Pharmacy: _____

The product(s): _____

Dates of ingestion(s): _____

Dosage of each ingestion: _____

Prescriber: _____

Pharmacy: _____

(Please copy and complete and attach additional pages, if necessary to provide a complete response.)

VI. DOCUMENTS

A. Authorizations - ORIGINAL SIGNED authorizations for the release of records in the forms appended hereto. You shall provide addressed authorizations for each health care provider, including hospitals, clinics and outpatient treatment centers, and any other custodian of records, including employers and educational institutions, you have identified above in your Answers to Sections III.C-D. and IV.A-H.

B. Documents in your possession - If you or your counsel have any of the following materials in your custody or possession, or in the possession, custody or control of your lawyers, please attach a copy to this Fact Sheet. This does not include privileged materials.

1. If you have been the claimant or subject of any personal injury lawsuit, worker's compensation, Social Security or other disability proceeding in the 5 years prior to ingestion of Reglan® and/or metoclopramide to present, all documents relating to such proceeding.

2. Copies of all medical records, bills, and any other documents from physicians, healthcare providers, hospitals, pharmacies, or others who have provided treatment to you in the 5 years prior to ingestion of Reglan® and/or metoclopramide to present, or that you otherwise identified in this Fact Sheet.

3. If you have ever had any radiological studies of the head, neck, or spine done in the 5 years prior to ingestion of Reglan® and/or metoclopramide to present, and you are in possession of such studies. If you are not in possession of such radiological studies, provide where these studies were done.

4. All insurance records, bills, letters, or other documents constituting, concerning, or relating to product use instructions, product warnings, package inserts, pharmacy handouts, or other materials distributed with or provided to you in connection with your use of Reglan® and/or metoclopramide.

5. Copies of advertisements, brochures, pamphlets, web pages, or other promotional material for Reglan® and/or metoclopramide.

6. Copies of the entire packaging, including the pills, bottle, box, and label for the Reglan® and/or metoclopramide you allege caused you injury and any remaining medication. (Plaintiff must maintain the originals of the items requested in this subpart.)

7. All statements obtained from or given by any person having knowledge of facts relevant to the subject of this litigation.

8. All documents relating to your purchase of Reglan® and/or metoclopramide, including, but not limited to, receipts, prescriptions, or records of purchase.

9. Any documents on which you relied in deciding to take Reglan® and/or metoclopramide.

10. All documents in your possession which you believe were provided to you (not to your lawyer) by defendant.

11. Representative photographs, drawings, slides or videos depicting the injuries you alleged Reglan® and/or metoclopramide caused.

12. All entries in journals, diaries, notes, letters, emails, or other documents written by you or received by you relating to your injuries, your use of Reglan® and/or metoclopramide, or the injuries you alleged Reglan® and/or metoclopramide caused (excluding privileged materials).

13. All documents relating to any communication by you to or from the Food & Drug Administration ("FDA"), including but not limited to on-line, telephoned, mailed, or faxed communications to the FDA's MedWatch program, regarding Reglan® and/or metoclopramide, including the dates of such communications.

14. If you claim you have suffered a loss of earnings or earning capacity, your federal W-2s for each of the last five (5) years.

15. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other healthcare provider.

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

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

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, information and belief and that I have supplied all the documents requested in Part VI of this Plaintiff Fact Sheet, to the extent that such documents are in my possession, and that I have signed and supplied the authorizations attached to this Verification.

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.

_____ _____

Signature Date

Sworn and subscribed before me
This _____ day of _____

_____

Notary Public