In Re: ACCUTANE® LITIGATION	SUPERIOR COURT OF NEW JERSEY LAW DIVISION: ATLANTIC COUNTY Case Code No. _____ **PLAINTIFF'S FACT SHEET** Plaintiff:_____ (name)

This Fact Sheet and the attached List of Medical Providers and Other Sources of Information must be completed by each plaintiff who used ACCUTANE® or their personal representative. 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, mental, emotional or psychological care or advice, and any pharmacy, 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 or your decedent;

(2) **"document"** means any writing or record or any type, however produced and whatever the medium on which it was produced or reproduced, and includes, without limitation, the original and any non-identical copy (whether different from the original because of handwritten notes or underlying on the copy or otherwise) and all drafts of papers, letters, telegrams, telexes, notes, notations, memoranda of conversations or meeting, calendars, diaries, 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 of description.

I. CASE INFORMATION

A. Name of person completing this form:_____

B. Please state the following for the civil action which you filed:

1. Case Caption:_____

2. Case No.:_____

3. Please state the name, address, and telephone number of the principal attorney representing you:

_____
Name

_____
Firm

_____
City, State and Zip Code

_____
Telephone number

4. When did you first contemplate obtaining an attorney regarding any injury(ies) which you now allege is associated with Accutane®?

_____

_____

5. When did you first contact an attorney regarding any injury(ies) which you now allege is associated with Accutane®? (This question asks for the first contact with any attorney including but not limited to your present attorney.)

_____

_____

C. If you are completing this questionnaire in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following: If not, skip this question.

1. _____
Your Name and Social Security Number

2. _____
Maiden Or Other Names Used or By Which You Have Been Known

3. _____
Street Address

4. _____
City, State and Zip Code

You may attach as many sheets of paper as necessary to fully answer these questions.

5. If you are in a representative capacity, state which individual or estate you are representing, and in what capacity you are representing the individual or estate:_____

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

_____ _____
Court Date of Appointment

7. Your relationship to deceased or represented person or person claimed to be injured:_____

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

If you are completing this questionnaire in a representative capacity, please respond to the remaining questions with respect to the person who used ACCUTANE®, unless the question instructs you otherwise. Those questions using the term "You" refer to the person who used the ACCUTANE®, unless you are instructed otherwise. 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. [This section will be tailored to the allegations in the complaint.]

D. Claim Information

1. What bodily injury(ies)/condition(s) do you claim resulted from your use of ACCUTANE®? If you state severe organ damage, please state specifically which organ and the alleged injury(ies). Be very specific about each and every injury claimed

_____
_____
_____

2. When do you claim this injury(ies)/condition(s) occurred?

_____
_____

3. Who diagnosed the condition(s)?

_____
_____
_____

4. Physician/healthcare provider(s) who related condition(s)/diagnosis(es) to Accutane®.

You may attach as many sheets of paper as necessary to fully answer these questions.

5. Date of diagnosis for each condition(s) alleged to have been caused by Accutane®.

6. Did you ever suffer this injury(ies) prior to the date set forth in answer to the prior question? If yes, when and who diagnosed the condition(s) at that time?

7. Do you claim that that your use of ACCUTANE® worsened a condition(s) that you already had or had in the past?

   Yes _____ No _____ Don't Know _____

   If yes, set forth the injury(ies) or condition(s); whether or not you had already recovered from that injury(ies) or condition(s) before you took ACCUTANE®; and the date of recovery, if any.

8. Is there a family history of the same or similar condition(s) you claim resulted from your use of Accutane®? (For example, if you claim Crohn's Disease, please list all gastrointestinal condition(s).)

   Yes _____ No _____

   If so, who (father, mother, brother, grandmother, etc.).

II. PERSONAL INFORMATION OF THE PERSON WHO USED ACCUTANE®

A. Last Name:_____
First Name:_____
Middle Name or Initial:_____

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

_____

C. Social Security Number:_____

D. Present Street Address:_____

_____

City State Zip Code

E. Identify each other address at which you have resided during the last ten (10) years, and list when you started and stopped living at each one:

_____ From _____ To _____

_____ From _____ To _____

_____ From _____ To _____

_____ From _____ To _____

_____ From _____ To _____

F. Identify each grammer/grade school, high school, college, university or other educational institution you have attended, the dates of attendance, courses of study pursued, and diplomas or degrees awarded:

_____

_____

_____

_____

_____

G. Employment Information.

1. Current employer (if not currently employed, last employer):

_____

Name

_____

Address

_____

Dates of Employment

_____

Occupation/Job Duties

You may attach as many sheets of paper as necessary to fully answer these questions.

2. List the following for each employer you have had in the last ten (10) years:

Name

Address

Dates of Employment

Occupation/Job Duties

Name

Address

Dates of Employment

Occupation/Job Duties

Name

Address

Dates of Employment

Occupation/Job Duties

You may attach as many sheets of paper as necessary to fully answer these questions.

H. Driver's License Number and State Issuing License: [If you have had drivers licenses in more than one state, list response for each state.]

_____

_____

I. Date and Place of Birth:_____

J. Sex: Male _____ Female ____

K. Military Service Information

1. Have you ever served in any branch of the U.S. Military?

Yes _____ No _____

If yes, please state:

1. What branch and the dates of service:

_____

2. Were you discharged for any reason relating to your physical, psychiatric or emotional condition(s)?

Yes _____ No _____

If yes, state what that condition(s) was.

_____

2. Have you ever been rejected from military service for any reason relating to your health or physical condition(s)?

Yes _____ No _____

If yes, state what that condition(s) was.

_____

3. Have you ever served in the military overseas?

Yes _____ No _____

If yes, state location and dates.

_____

L. Insurance/Claim Information

1. Have you ever filed a worker's compensation claim?

Yes _____ No _____

If yes, please state:

1. Year claim was filed:_____
2. Court/State where claim was filed:_____
3. Claim/ docket number, if applicable:._____
4. Nature of disability:_____

You may attach as many sheets of paper as necessary to fully answer these questions.

5. Period of disability:_____

6. Benefits received, if any:_____

[Attach additional sheets if necessary to provide all of this information for more than one claim]

2. Have you ever filed a social security disability claim (SSI or SSD)?

Yes _____ No _____

If yes, please state

1. Year claim was filed:_____

2. Where claim was filed:_____

3. Nature of disability:_____

4. Period of disability:_____

5. Benefits received, if any:_____

[Attach additional sheets if necessary to provide all of this information for more than one claim]

3. 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 when, the name of the company and the company's stated reason for denial:

_____

_____

4. ***(Answer this question if you are claiming damages for mental or emotional distress.)*** 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 when, the name of the company and the company's stated reason for denial:

_____

_____

_____

5. Has any insurance 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 your alleged injury(ies) through the present?

Yes _____ No _____

If yes, then as to each company, separately state:
Name of the company:_____
Address of the company:_____
The account/policy number or designation:_____
Dates of coverage:_____
When claim was made:_____

6. Have you ever been out of work for more than thirty (30) days for reasons related to your health? If yes, set forth when and the reason.

Yes _____ No _____

When: _____
Reason: _____
_____

7. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury(ies)?

Yes _____ No _____

If so, state the court in which such action was filed, the caption, case name and/or names of adverse parties, and the civil action or docket number assigned to each claim, action or suit, and a brief description for the claims asserted.

_____
_____
_____

M. Have you ever been convicted of a crime? If yes, set forth where, when and the crime.

Yes _____ No _____

_____
_____
_____

You may attach as many sheets of paper as necessary to fully answer these questions.

FAMILY INFORMATION

N. List for each marriage the name of your spouse; spouse's date of birth (for your current spouse only); spouse's occupation; date of marriage; date the marriage ended, if applicable; and how the marriage ended (e.g., divorce, annulment, death):

_____

_____

_____

_____

_____

O. List the names of your parents and whether they are still married.

_____

_____

_____

P. List the names of your paternal and maternal grandparents and whether they are still living. If deceased, list date and cause of death.

_____

_____

_____

Q. To the best of your current knowledge or present recollection, has any parent, grandparent, child, or sibling ever been diagnosed with a problem or condition(s) relating to the same organ or organ system identified in your answer to Section I(D)?

Yes _____ No _____ Don't Know _____

If yes, identify each such person below and provide the information requested.

1. Name:_____
   Current Age (or Age at Death):_____
   Type of Problem:_____
   If Applicable, Cause of Death:_____

2. Name:_____
   Current Age (or Age at Death):_____
   Type of Problem:_____
   If Applicable, Cause of Death:_____

3. Name:_____
   Current Age (or Age at Death):_____
   Type of Problem:_____
   If Applicable, Cause of Death:_____

You may attach as many sheets of paper as necessary to fully answer these questions.

R. If applicable, for each of your children, list his/her name, age, occupation and address:

_____
_____
_____
_____
_____

S. If you are bringing a survivor cause of action, state whether you have been appointed as the decedent's personal representative authorized to prosecute the decedent's claims, and when and by whom you were so appointed.

_____
_____
_____
_____
_____

III. CURRENT MEDICAL CONDITION(S)

A. Do you currently suffer from any physical injuries, illnesses or disabilities other than those you alleged are the result of your use of ACCUTANE®?

Yes _____ No _____

B. If the answer is yes, please state the following for each injury(ies), illness or disability:

1. Identify the injury(ies), illness, or disability, their symptoms and date of onset. Injury(ies), illness, or disability, and their symptoms:

_____
_____
_____
_____
_____

Date of onset: _____

2. By whom first diagnosed:

_____ _____
Name Address (if not otherwise provided)

_____
Date of diagnosis

You may attach as many sheets of paper as necessary to fully answer these questions.

IV. MEDICAL BACKGROUND

A. Height:_____

B. Current Weight:_____
Weight at the time of the injury, illness, or disability described in section I(D):

_____

C. Prescription Medicines

1. To the best of your recollection, list each prescription medicine, including but not limited to oral contraceptives (as applicable), you have taken regularly in the last ten (10) years, identifying the medication and the condition(s) for which it was prescribed.

_____
_____
_____
_____
_____
_____
_____
_____

2. To the best of your recollection, list each prescription medicine you have taken intermittently in the last ten (10) years, identifying the medication and the condition(s) for which it was prescribed.

_____
_____
_____
_____
_____
_____

3. To the best of your recollection, state whether you used any of the following from ten (10) years prior to the date of the injury(ies) you allege in section I(D) through the present, circle all medications you have used, when you took the medication and how frequently, and if a doctor prescribed or suggested the medication, identify the doctor.

a. NSAIDS (such as):

Substance	When taken and How Frequently	Prescribing Doctor (if any)
Advil	_____	_____
Ibuprofen	_____	_____

You may attach as many sheets of paper as necessary to fully answer these questions.

Substance	When taken and How Frequently	Prescribing Doctor (if any)
Aleve		
Naprosyn		
Motrin		
Orudis		
Feldene		
Indocin		
Toradol		
Daypro		
Celebrex		

b. Herbal Remedies or Supplements:

Substance	When taken and How Frequently	Prescribing Doctor (if any)
Kava		
Ginseng		
Ginko Bilboa		
St. John's Wort		
Sal Palmetto		

D. Smoking/Tobacco Use History (circle whichever is applicable):

1. Never smoked cigarettes/cigars/pipe tobacco or used chewing tobacco/snuff.

2. Past smoker of cigarettes/cigars/pipe tobacco or used chewing tobacco/snuff.
Date on which smoking/tobacco use ceased:_____
Amount smoked or used: _____ per day for _____ years.

3. Current smoker of cigarettes/cigars/pipe tobacco or user of chewing tobacco/snuff.
Amount smoked or used: _____ per day for _____ years.

E. Drinking History:

1. Do you now drink or have you in the past drunk alcohol (beer, wine, whiskey, etc.)?

Yes _____ No _____

If no, go to Section F below. If yes, check the following box which represents your greatest alcohol consumption over an extended (6 months or greater) period within the last 10 years:

_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 11-14 drinks per week
_____ 15 or more drinks per week
_____ Other (describe)_____

Check the following box which represents your weekly alcohol consumption for the month prior to the first symptom (gastrointestinal or other symptoms related to your injury) you experienced:

_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 11-14 drinks per week
_____ 15 or more drinks per week
_____ Other (describe)_____

F. Caffeine and Sugar Intake History:

1. Do you now or have you in the past consumed caffeinated beverages (coffee, tea, sodas, etc.)?

Yes _____ No _____

If yes, check the following box which represents your greatest caffeine consumption over an extended (6 months or greater) period within the last 10 years:

_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 11-14 drinks per week
_____ 15 or more drinks per week
_____ Other (describe)_____

Check the following box which represents your weekly caffeine consumption for the month prior to the time that you sustained the injuries alleged in the complaint:

_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 11-14 drinks per week
_____ 15 or more drinks per week
_____ Other (describe)_____

2. Do you now or have you in the past consumed sugared beverages or desserts?

Yes _____ No _____

If yes, check the following box which represents your greatest sugar consumption over an extended (6 months or greater) period within the last 10 years:

_____ 1-5 items per week
_____ 6-10 items per week
_____ 11-14 items per week
_____ 15 or more items per week
_____ Other (describe)_____

Check the following box which represents your weekly sugar consumption for the month prior to the time that you sustained the injuries alleged in the complaint:

_____ 1-5 items per week
_____ 6-10 items per week
_____ 11-14 items per week
_____ 15 or more items per week
_____ Other (describe)_____

G. ***If you are claiming damages for mental or emotional distress as a consequence of ACCUTANE®,*** state whether you have experienced or been treated for any psychological, psychiatric or emotional problem prior to the use of ACCUTANE®, 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, paranoid, borderline, histrionic, other), generalized anxiety disorder, social phobia/anxiety disorder, mania, poor sleep, poor concentration, suicidal thoughts/attempts, and drug abuse.

Yes _____ No _____

If yes, state:

1. Name and address of each health care provider who treated you:

_____
Name

_____
Address (if not otherwise provided)

_____

2. Condition(s) for which treated:_____
3. When treated:_____
4. Medications prescribed for such condition(s):_____

_____

You may attach as many sheets of paper as necessary to fully answer these questions.

H. To the best of your knowledge or understanding, have you ever experienced, or been told by a doctor or other healthcare professional, that you have, may have or had any of the following at any time in your life.

Symptom/Condition	Yes	No	I don't know
Abdominal pain			
Allergic reaction to medication			
Anemia			
Arthritis			
Back pain and/or neck injury			
Bleeding/clotting disorders (hemophilia, Von Willebrand's disease, scurvy, other)			
Blood Disorders			
Blood in stool or dark/black stools			
Blurry vision lasting more than a few days			
Bone fracture			
Bone problems/pain/disease			
Calcification of Tendons and Ligaments			
Cancer (lung, colon, liver, breast, testicular, other)			
Chest pain/angina (at rest or with exertion)			
Chronic Fatigue Syndrome			
Chronic obstructive pulmonary disease/COPD			
Colitis			
Congenital heart disease			
Congestive heart failure			
Corneal Opacity			
Corneal Ulcer			
Coronary artery disease			
Coronary heart disease			
Crohn's Disease			
Deep vein thrombosis/DVT/blood clot in lower legs			
Degenerative disc			
Dermatomyositis			

Symptom/Condition	Yes	No	I don't know
Diabetes			
Dizziness lasting more than a few days			
Drowsiness lasting more than a few days			
Elevated cholesterol			
Elevated liver enzymes			
Elevated triglycerides			
Esophagus problems (strictures, achalasia, esophagitis, Barrett's esophagus, difficulty swallowing, other)			
Eye hemorrhages			
Fibromyalgia			
Gall bladder problems (gall stones, other)			
Gastrointestinal problems			
Gout			
Headaches lasting more than a few days			
Heart attack/MI/myocardial infarction			
Heart problems (including but not limited to heart attack, heart murmurs, heart valve problems, heart palpitations, heart rate/rhythm problems, congestive heart failure, cor pulmonale, etc.)			
Heartburn/ reflux/ esophageal reflux disease/ GERD			
Hepatotoxicity			
Hernia (strangulated or incarcerated)			
High blood pressure/hypertension			
High triglycerides			
Hodgkin's disease/ non-Hodgkin's lymphoma			
Hypoxia (low oxygen saturation)			
Ileitis			
Inflammatory bowel disease			
Insomnia lasting more than a few days			
Intestinal hemorrhage			
Intestinal obstruction (not including constipation)			

You may attach as many sheets of paper as necessary to fully answer these questions.

Symptom/Condition	Yes	No	I don't know
Irregular heart rhythm			
Irritable bowel syndrome			
Itching (persistent lasting more than one week)			
Joint pain lasting more than a few days			
Keratitis			
Kidney problems (disease, infection, stones, protein in urine, etc.)			
Leukemia			
Liver disease (hepatitis B/C, cirrhosis, cysts, abnormal enzymes, etc.)			
Lupus			
Lymphadenopathy			
Measles			
Musculoskeletal problems			
Nausea (repetitive bouts lasting more than a few days)			
Night vision loss			
Obesity			
Optic neuritis			
Oral herpes (canker sores)			
Osteoarthritis			
Pancreatitis			
Paresthesias			
Peptic ulcer disease			
Peripheral vascular disease			
Premature epiphyseal closure			
Pseudotumor cerebri psychosis			
Pulmonary embolism/blood clot in the lung			
Pyoderma faciale			
Rectal bleeding			
Regional ileitis			

You may attach as many sheets of paper as necessary to fully answer these questions.

Symptom/Condition	Yes	No	I don't know
Rheumatic fever (as to you only, if applicable)			
Rhabdomyolysis			
Rheumatoid arthritis			
Scheuermann's Kyphosis			
Seizure disorder			
Shortness of breath not associated with vigorous exercise			
Silent MI			
Skeletal hyperostosis			
Sleep apnea			
Stomach problems (ulcers, perforations, bleeding)			
Stroke			
Swelling/edema/fluid in legs ankles (other than in pregnancy)			
Syncope			
Tendonitis			
Thyroid disorder and/or goiter			
Transient chest pain			
Transient ischemic attack/TIA			
Tuberculosis			
Ulcerative colitis			
Urogenital condition(s)s			
Vascular problems			
Vascular thrombotic disease			
Vasculitis			
Vision problems lasting more than a few days			
Vomiting lasting more than a few days			

I. If you responded "yes" to any of the above, please identify/state the condition(s), the date of onset, any medication prescribed to treat the condition(s), and the name of the physician or other person who made the

diagnosis or informed you of the condition(s) and their address if not provided in the accompanying list.

1. Condition(s):_____
Onset date and medication:_____
Name and address of physician or other person:_____
_____

2. Condition(s):_____
Onset date and medication:_____
Name and address of physician or other person:_____
_____

3. Condition(s):_____
Onset date and medication:_____
Name and address of physician or other person:_____
_____

4. Condition(s):_____
Onset date and medication:_____
Name and address of physician or other person:_____
_____

5. Condition(s):_____
Onset date and medication:_____
Name and address of physician or other person:_____
_____

J. Please indicate whether you have ever received any of the following treatments or diagnostic procedures:

1. Surgeries, including but not limited to the following, and specify for what condition(s) the surgery was performed: open heart/bypass surgery, vascular surgery, intestinal surgery, etc..

Surgery and condition(s) for which it was performed:_____
_____
_____
When:_____
Treating physician:_____
_____
Hospital:_____
_____

2. Treatments/interventions for heart attack, angina (chest pain), or lung ailments, including but not limited to the following: cardiac catheterization, angioplasty (balloon), stenting, electroconversion.

Treatment/intervention:_____
_____
_____
When:_____

You may attach as many sheets of paper as necessary to fully answer these questions.

Treating physician:_____

_____

Hospital:_____

_____

3. Have you had any of the following tests performed: chest X-ray, CT scan, MRI, any other type of x-ray, colonoscopy, upper or lower GI, EKG, echocardiogram, bleeding scan, endoscopy, lung bronchoscopy, carotid duplex/ultrasound, or CT scan of the head. If so, answer the following:

Diagnostic test:_____

_____

When:_____

Treating physician:_____

_____

Hospital:_____

_____

Reason:_____

_____

K. Have you ever participated in any clinical trials or studies relating to any drugs or treatments for any medical condition(s)s?

Yes _____ No _____

If "Yes", please identify:
Name of the trial or study:_____
Sponsor of trial or study:_____
Drug or treatment studied:_____
Purpose of the drug or treatment studied:_____
Name and address of the investigator in charge of your care and treatment in the trial or study:_____

_____

The dates you participated in the trial or study:_____

L. To the best of your knowledge, have your parents, grandparents, children or siblings ever experienced or been diagnosed with, or been told by a doctor or other healthcare professional, that they have, may have or had any of the following (circle all that apply), set forth the name of the individual and their relationship to you next to each condition(s) circled?

Symptom/Condition	Name of Individual		Relationship
Gastrointestinal pain (repetitive bouts)			
Blood in stool or dark/black stools			
Bone pain/problems/disease			
Cancer (lung, colon, liver, breast,			

You may attach as many sheets of paper as necessary to fully answer these questions.

testicular, other)			
Depression/Psychiatric disorders			
Diabetes			
Elevated cholesterol/lipids			
Heart problems of any type including arthrosclerotic disease			
Any kind of bowel disease/disorder (including Crohn's, ulcerative colitis or irritable bowel syndrome)			
Kidney disease/stones			
Liver disease (hepatitis B/C, cirrhosis, cysts, other)			
Lupus			
Musculoskeletal disease/disorder			
Pancreatitis			
Stroke			
Thyroid disease/disorder (goiter, etc.)			
Vision disorder			

You may attach as many sheets of paper as necessary to fully answer these questions.

V. ACCUTANE® PRESCRIPTION INFORMATION

A. Who prescribed ACCUTANE® for you?

B. On which dates did you begin to take, and stop taking, ACCUTANE®? If you took Accutane® more than once, list each date and the start and stop date.

C. For what condition(s) were you prescribed ACCUTANE®?

D. Did you renew your prescription for ACCUTANE®? If yes, how many times?

E. Where were you living when you took ACCUTANE®?

F. Pharmacy Information. If you received a prescription for ACCUTANE®, state for each prescription the name and address of the pharmacy where it was filled, and the number of times it was filled:

G. 1. Have you had discussions with any doctor about whether your claimed injury(ies) is related to the use of ACCUTANE®?

Yes _____ No _____

You may attach as many sheets of paper as necessary to fully answer these questions.

2. Identify the doctor or doctors with whom you had such discussions.

_____

_____

Name

_____

_____

Address (if not otherwise provided)

[If discussed with more than one doctor, please copy and complete Part 2 for each.]

H. State whether you requested that any doctor or clinic provide you with ACCUTANE® or a prescription for ACCUTANE®.

Yes _____ No _____

I. Were you given any written instructions or warnings regarding the use of ACCUTANE®?

Yes _____ No _____

If yes, state:

1) When the written instructions or warnings were given:

_____

_____

2) A description of the written warnings or instructions (e.g., package insert, patient product information; pharmacy handout, etc.):

_____

_____

_____

3) Identify each person or entity from whom you received the warnings or instructions:_____

_____

_____

Approximate date you received the written instructions or warnings:_____

_____

Summary of instructions/warnings received:_____

_____

_____

J. What other medications (including aspirin), if any, were you taking at the same time you were taking ACCUTANE®?

_____

_____

_____

_____

_____

K. 1. To the best of your recollection what other medications (other than those set forth elsewhere in the Fact Sheet) including, but not limited to, oral

contraceptives (as applicable) and over-the-counter medication, had you taken five (5) years before you took Accutane®, and when did you take them? Please also state when you took the medication, how frequently and if prescribed by a physician, the name of the physician.

2. Do you believe you ever experienced gastrointestinal problems or other adverse side effects from any or all of these other medications? If yes, list the type of adverse side effect, the medication you were taking and the date(s) on which you experienced the adverse side effect.

3. Did you believe you experienced any of the adverse side effects listed in your answer to the preceding question while taking ACCUTANE®? If so, set forth which adverse side effect you experienced, when, what treatment you received for the adverse side effect, and who prescribed that treatment.

L. On what date, and in what city and state, did you first experience any symptoms you believe are related to the injury(ies) alleged in your complaint and what were those symptoms?

M. Were there any witnesses to the symptoms identified above? If so, state their names, addresses, phone numbers and relationships to you.

N. When did you first contact a doctor or healthcare professional concerning this injury(ies)? Whom did you contact?

You may attach as many sheets of paper as necessary to fully answer these questions.

O. If you were taken to a doctor or health care facility for the injury(ies) alleged in your complaint, state the name and address of the persons, police department, fire department, emergency medical workers, or ambulance company that took you to the doctor or health care facility.

_____

_____

P. Wage Loss Claims. ***Answer these questions if you claim or expect to claim that you lost earnings or impairment of earning capacity as a result of any condition(s) that you believe was caused by your use of ACCUTANE®: [If you are not claiming lost wages, skip this section.]***

1. State the total amount of time you have lost from work as a result of any condition(s) that you claim or believe was caused by your use of ACCUTANE® and the amount of income that you lost.

_____

_____

2. State your total earned income (including salary, bonus, and benefits) for each of the last 10 years.

Year	Income
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____

Q. Have you paid or incurred any medical expenses that are related to any condition(s) that you claim or believe was caused by your use of ACCUTANE® and for which you seek recovery in the action you have filed?

Yes_____ No_____

If yes, state the total amount of such expenses at this time: $_____

R. Has your insurer, or any other entity or person, paid or incurred any medical expenses that are related to any condition(s) that you claim or believe was caused by your use of ACCUTANE® and for which you seek recovery in the action you have filed?

Yes_____ No_____

If yes, state the total amount of such expenses at this time: $_____

S. Emotional Distress Claims. ***If you are claiming damages for mental or emotional distress,*** describe the kind of injury(ies) you allege and when you allegedly suffered it, and list all individuals from whom you received treatment for such injury(ies) and the dates on which treatment was received.

T. Please identify all person who you believe possess information relevant to your claims in this matter and for each, state his or her name, address, telephone number and a description of the information you believe he or she possesses.

VI. DOCUMENTS AND THINGS

Attach copies of the following non-privileged documents and things to this declaration, to the extent that such materials are currently in your possession, custody, or control, in the possession, custody, or control of your parents, guardians or spouse, or in the possession, custody, or control of your lawyers.

A. A copy of all prescriptions for ACCUTANE®, any unused ACCUTANE® you received as a result of such prescriptions, receipts, physician or office records, drug containers, packaging and other records that show the period during which you have taken ACCUTANE®, the dosage of ACCUTANE® and the frequency with which you took ACCUTANE®.

B. All documents that refer or relate to ACCUTANE® obtained from the Food and Drug Administration or other government agencies.

C. If you have been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding.

D. Copies of all documents from physicians, hospitals, clinics, or any type of health care provider relating to your medical or mental health history. This would include, but not be limited to hospital records, diagnostic test or test results, lab work, rehab records, doctor's office charts, etc.

E. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, consent forms, pharmacy

handouts or other materials distributed or provided to you when your prescriptions for ACCUTANE® were filled.

F. Copies of all advertisements or promotions for ACCUTANE® received or reviewed before filing this action.

G. Executed authorizations.

H. If you claim you have suffered loss of earnings or earning capacity, all documents that evidence your income/earnings for each of the last ten (10) years.

I. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider and statements and explanations of benefits from your health care insurer or plan.

J. Copies of letters testamentary, letters of administration, powers of attorney, guardianship or guardian *ad litem* orders or other documents relating to your status as plaintiff if you are suing on behalf of another individual.

K. Decedent's death certificate (if applicable).

L. Report of autopsy, medical examiner, coroner, toxicology, or toher police or investigative reports (if applicable);

M. Copies of all documents concerning your education including, but not limited to, records of and from all schools attended including but not limited to report cards, progress reports, attendance records, disciplinary reports, transcripts, guidance or counseling records and any class yearbooks.

N. All documents authored by you which document, record or reflect your physical or mental condition or state of mind before, during and after ACCUTANE® use, including but not limited to diaries or journals, suicide notes, and written or electronic communications.

You may attach as many sheets of paper as necessary to fully answer these questions.

CERTIFICATION

I certify under penalty of perjury that all of the information provided in this Fact Sheet is true and correct to the best of my knowledge, that I have completed the List of Medical Providers and Other Sources of Information appended hereto, which is true and correct to the best of my knowledge, that I have supplied all the documents requested in part VIII of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and that I have supplied the authorizations attached to this declaration. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____
Print Name

_____ _____
Signature Date

_____
Print Name
(Loss of Consortium Plaintiff)

_____ _____
Signature Date

You may attach as many sheets of paper as necessary to fully answer these questions.

LIST OF MEDICAL PROVIDERS
AND OTHER SOURCES OF INFORMATION

EACH PLAINTIFF IS REQUIRED TO FULLY AND ACCURATELY TO THE BEST OF THEIR RECOLLECTION COMPLETE THIS FORM LISTING MEDICAL CARE PROVIDERS AND OTHER SOURCES OF INFORMATION AS REQUESTED.

List the name and address of each of the following:

A. Your current family and/or primary care physician:

_____
Name

_____
Street Address

_____
City, State, Zip Code

B. To the best of your ability, identify each of your primary care physicians for the last ten (10) years. [See definitions as set forth on page 1.]

1. _____ _____
Name Approximate dates

_____
Last known address

_____
City, State, Zip Code

2. _____ _____
Name Approximate dates

_____
Last known address

_____
City, State, Zip Code

3. _____ _____
Name Approximate dates

_____
Last known address

_____
City, State, Zip Code

You may attach as many sheets of paper as necessary to fully answer these questions.

4. _____ _____
Name Approximate dates

_____
Last known address

_____
City, State, Zip Code

5. _____ _____
Name Approximate dates

_____
Last known address

_____
City, State, Zip Code

C. Each hospital, clinic, or healthcare facility where you have received inpatient treatment during the last ten (10) years.

1. _____
Name

_____
Street Address

_____
City, State, Zip Code

_____
Dates of Admission

_____
Reason for Admission

2. _____
Name

_____
Street Address

_____
City, State, Zip Code

_____
Dates of Admission

_____
Reason for Admission

You may attach as many sheets of paper as necessary to fully answer these questions.

3. _____

Name

_____

Street Address

_____

City, State, Zip Code

_____

Dates of Admission

_____

Reason for Admission

4. _____

Name

_____

Street Address

_____

City, State, Zip Code

_____

Dates of Admission

_____

Reason for Admission

5. _____

Name

_____

Street Address

_____

City, State, Zip Code

_____

Dates of Admission

_____

Reason for Admission

D. Each hospital, clinic, or healthcare facility where you have received outpatient treatment (including treatment in an emergency room) during the last ten (10) years.

1. _____

Name

_____

Street Address

_____

City, State, Zip Code

_____

Dates of Admission

_____

Reason for Admission

You may attach as many sheets of paper as necessary to fully answer these questions.

2. _____
Name

_____
Street Address

_____
City, State, Zip Code

_____
Dates of Admission

_____
Reason for Admission

3. _____
Name

_____
Street Address

_____
City, State, Zip Code

_____
Dates of Admission

_____
Reason for Admission

4. _____
Name

_____
Street Address

_____
City, State, Zip Code

_____
Dates of Admission

_____
Reason for Admission

5. _____
Name

_____
Street Address

_____
City, State, Zip Code

_____
Dates of Admission

_____
Reason for Admission

You may attach as many sheets of paper as necessary to fully answer these questions.

E. Each physician or healthcare provider from whom you have received treatment in the last ten (10) years.

1. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

_____
Dates of Treatment

2. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

_____
Dates of Treatment

3. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

_____
Dates of Treatment

4. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

_____
Dates of Treatment

You may attach as many sheets of paper as necessary to fully answer these questions.

5. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

_____
Dates of Treatment

6. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

_____
Dates of Treatment

7. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

_____
Dates of Treatment

8. _____
Name

_____
Specialty

_____
Street Address

_____
City, State, Zip Code

_____
Dates of Treatment

You may attach as many sheets of paper as necessary to fully answer these questions.

9. _____

Name

_____

Specialty

_____

Street Address

_____

City, State, Zip Code

_____

Dates of Treatment

10. _____

Name

_____

Specialty

_____

Street Address

_____

City, State, Zip Code

_____

Dates of Treatment

F. Each pharmacy where you filled or obtained prescription medication in the last ten (10) years.

1. _____

Name

_____

Street Address

_____

City, State, Zip Code

2. _____

Name

_____

Street Address

_____

City, State, Zip Code

G. If you have submitted a claim for social security disability benefits in the last ten (10) years, state the name and address of the office which is most likely to have records concerning your claim. Name Street Address

_____

Name

_____

You may attach as many sheets of paper as necessary to fully answer these questions.

Street Address

City, State, Zip Code

H. If you have submitted a claim for worker's compensation, state the name and address of the entity which is most likely to have records concerning your claim.

Name

Street Address

City, State, Zip Code

You may attach as many sheets of paper as necessary to fully answer these questions.

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY

In re: ACCUTANE® LITIGATION	Case No. 619 **AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS PURSUANT TO 45 C.F.R. § 164.508 (HIPAA)**

Name:_____

Date of Birth:_____

Social Security Number:_____

I hereby authorize _____ to release all existing medical records and information regarding the above-named person's medical care, treatment, physical condition(s), and/or medical expenses revealed by observation or treatment past, present and future to the law firm of **GIBBONS, DEL DEO, DOLAN, GRIFFINGER & VECCHIONE, One Riverfront Plaza, Newark, NJ 07102-5497 and/or its designated agent.** These records shall be used solely in connection with the currently pending litigation involving the person named above. This authorization shall cease to be effective as of the date on which that litigation concludes.

I understand that the health information being used/disclosed may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

This authorization also may include x-ray reports, CT scan reports, MRI scans, EEGs, EKGs, sonograms, arteriograms, fetal monitor strips, discharge summaries, photographs, surgery consent forms, informed consent forms regarding family planning, admission and discharge records, operation records, doctor and nurses notes (excluding psychotherapy notes maintained separately from the individual's medical record that document or analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session by referring to something other than medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress), prescriptions, medical bills, invoices, histories, diagnoses, narratives, and any correspondence/memoranda and billing information. It also includes, to the extent such records currently exist and are in your possession, insurance records, including Medicare/Medicaid and other public assistance claims, applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other foams of public assistance (federal, state, local, etc.). This listing is not meant to be exclusive.

You may attach as many sheets of paper as necessary to fully answer these questions.

I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition(s) of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition(s) the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of Gibbons, Del Deo, Dolan, Griffinger & Vecchione.

Dated this _____ day of _____, 200_

_____

[PLAINTIFF OR REPRESENTATIVE]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:

_____

_____

_____

_____

_____

You may attach as many sheets of paper as necessary to fully answer these questions.

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY

In re: ACCUTANE® LITIGATION

Case No. 619

AUTHORIZATION FOR RELEASE OF PSYCHOLOGICAL/PSYCHIATRIC RECORDS PURSUANT TO 45 C.F.R. § 164.508 (HIPAA)

Name:_____

Date of Birth:_____

Social Security Number:_____

I hereby authorize _____ to release all existing records and information regarding the above-named person's psychological or psychiatric care, treatment, condition(s), and/or expenses revealed by observation or treatment past, present and future to the law firm of **GIBBONS, DEL DEO, DOLAN, GRIFFINGER & VECCHIONE, One Riverfront Plaza, Newark, NJ 07102-5497 and/or its designated agent.** These records shall be used solely in connection with the currently pending litigation involving the person named above. This authorization shall cease to be effective as of the date on which that litigation concludes.

I understand that this authorization includes information regarding the diagnosis and treatment of psychiatric and psychological disorders, and that the health information being used/disclosed may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

This authorization also may include x-ray reports, CT scan reports, MRI scans, EEGs, EKGs, sonograms, arteriograms, fetal monitor strips, discharge summaries, photographs, surgery consent forms, informed consent forms regarding family planning, admission and discharge records, operation records, doctor and nurses notes (excluding psychotherapy notes maintained separately from the individual's medical record that document or analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session by referring to something other than medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress), prescriptions, medical bills, invoices, histories, diagnoses, psychiatric treatment and counseling records, psychological treatment and counseling records, narratives, and any correspondence/memoranda and billing information. It also includes, to the extent such records currently exist and are in your possession, insurance records, including Medicare/Medicaid and other public assistance claims, applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as

evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, etc.). This listing is not meant to be exclusive.

I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition(s) of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition(s) the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of Gibbons, Del Deo, Dolan, Griffinger & Vecchione.

Dated this _____ day of _____, 200_

_____

[PLAINTIFF OR REPRESENTATIVE]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:

_____

_____

_____

_____

_____

You may attach as many sheets of paper as necessary to fully answer these questions.

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY

In re: ACCUTANE® LITIGATION

Case No. 619

AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY NOTES PURSUANT TO 45 C.F.R. § 164.508 (HIPAA)

Name:_____

Date of Birth:_____

Social Security Number:_____

I hereby authorize _____ to release all existing psychotherapy notes regarding the above-named person's medical care, treatment, physical/mental condition(s), and/or medical expenses revealed by observation or treatment past, present and future to the law firm of **GIBBONS, DEL DEO, DOLAN, GRIFFINGER & VECCHIONE, One Riverfront Plaza, Newark, NJ 07102-5497 and/or its designated agent.** These records shall be used solely in connection with the currently pending litigation involving the person named above. This authorization shall cease to be effective as of the date on which that litigation concludes.

I understand that this authorization includes all psychotherapy notes maintained separately from the above-named person's medical record that document or analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session by referring to something other than medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress.

I understand that the health information being disclosed by these psychotherapy notes may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition(s) of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition(s) the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation.

You may attach as many sheets of paper as necessary to fully answer these questions.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of Gibbons, Del Deo, Dolan, Griffinger & Vecchione.

Dated this _____ day of _____, 200_

_____

[PLAINTIFF OR REPRESENTATIVE]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:

_____

_____

_____

_____

_____

PABOS2:CHENNES:616832_1
14690-91141

You may attach as many sheets of paper as necessary to fully answer these questions.

#96075 v5
036835-50206

PLAINTIFF'S
CONFIDENTIAL FACT SHEET
NOT TO BE RELEASED

A. Illicit Drugs

1. a) Have you ever used (even one time) any illicit drugs of any kind within one (1) year before, or any time after, you first experienced your alleged ACCUTANE®-related injury(ies)?"

Yes _____ No _____

b) If "Yes", identify each substance and state when you first and last used it.

_____
_____
_____
_____
_____

B. To the best of your knowledge, have you ever experienced, or been told by a doctor or other healthcare professional, that you have, may have or had any of the following at any time in your life (circle all that apply)?

Symptom/Condition	Yes	No	Unsure
Alcoholism			
Depression			
Eating disorders (anorexia, bulimia, etc.)			
Hepatitis			
HIV/AIDS			
Mental disorders			
Oral Herpes (canker sores), Herpes Zoster, Shingles			
Psychiatric problems			
Suicidal ideation			
Syphilis			

C. (*If you are claiming psychiatric injuries as a consequence of Accutane*):To the best of your knowledge, have you ever experienced, or been told by a doctor or other healthcare professional, that you have, may have or had any of the following at any time in your life (circle all that apply)?

Symptom/Condition	Yes	No	Unsure
Anorexia			
Anxiety			

Bulimia			
Catatonic behavior			
Decrease or increase in appetite, lasting more than a few days.			
Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)			
Delusions			
Depersonalization (being detached from oneself)			
Depressed mood ,lasting more than a few days.			
Derealization (feelings of unreality)			
Difficulty concentrating or mind going blank, lasting more than a few days.			
Diminished ability to think or concentrate, or indecisiveness, lasting more than a few days.			
Disorganized speech			
Distractibility (i.e. attention too easily drawn to unimportant or irrelevant external stimuli), lasting more than a few days.			
Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)			
Fatigue or loss of energy, lasting more than a few days.			
Fear of losing control or going crazy			
Feelings of hopelessness			
Feelings of worthlessness or excessive or inappropriate guilt (not merely self-reproach or guilt about being sick), lasting more than a few days.			
Flat Affect			
Flight of ideas or subjective experience that thoughts are racing			
Hallucinations			
Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation			

Inflated self-esteem or grandiosity			
Insomnia, lasting more than a few days.			
Intense fear of gaining weight or becoming fat, even though underweight			
Irritability, lasting more than a few days.			
Low self-esteem, lasting more than a few days.			
Marked and persistent fear of social or performance situations together with either intense anxiety during such situations or the avoidance of such situations			
Markedly diminished interest or pleasure in all, or almost all activities, lasting more than a few days.			
More talkative than usual or pressure to keep talking, lasting more than a few days			
Panic attacks			
Phobias			
Psychomotor agitation or retardation			
Psychosis or psychotic			
Recurrent thoughts of death (not just fear of dying)			
Restlessness or feeling keyed up or on edge together with anxiety			
Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month)			
Sleep disturbance (difficulty following or staying asleep , or restless unsatisfying sleep), lasting more than a few days.			
Suicidal ideation			
Suicide attempt or a specific plan for committing suicide			

D. (*If you are claiming psychiatric injuries as a consequence of Accutane*): If you responded "yes" to anything in C. above, please identify/state the condition(s), the date of onset, any medication prescribed to treat the condition(s), and the name of the physician or other person who made the diagnosis or informed you of the condition(s) and their address if not otherwise herein provided.