

IN RE DIET DRUG LITIGATION VENUED IN BERGEN COUNTY

DOCKET NO. BER-7718-03

AMENDED PLAINTIFF FACT SHEET

This Fact Sheet and the attached Riders must be completed by each plaintiff in the Bergen County Diet Drug Litigation who used diet drugs or who is the representative of a person or the estate of a deceased person who used diet drugs. All responses must to the best of each plaintiff's or the plaintiff's representative's knowledge and recollection.

I. CASE INFORMATION

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

1. Case Caption: _____

2. Docket No.: _____

3. Court in which action is brought:

4. Please state name, address, telephone number, fax number and E-mail address of principal attorney representing you.

Name

Firm

City, State and Zip Code

Telephone number Fax number

E-mail address

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

1. _____
Your Name
2. _____
Street Address
3. _____
City, State and Zip Code
4. In what capacity are you representing the individual:

5. If you were appointed by a court, state the:

Court	Date of Appointment
6. Your relationship to deceased or represented person:

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

[If you are completing this questionnaire in a representative capacity, please respond to the remaining questions with respect to the person who used diet drugs. Those questions using the term "You" refer to the person who used the diet drugs. 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.]

C. Claim Information

1. Do you claim that you have suffered a bodily injury as the result of the use of Pondimin (fenfluramine), Redux (dexfenfluramine) or phentermine?¹

Yes _____ No _____
2. If the answer to the foregoing questions is "Yes", state the nature of the injury or injuries which you claim.

¹ For description of phentermine products see chart in Part V.

*For description of phentermine products see chart in Part V.

3. If you do not claim you have suffered a bodily injury as the result of the use of Pondimin, Redux and/or phentermine, state how you have been injured.

4. State the name, address, telephone number and relationship to you of all persons who have knowledge of any facts relating to this case, and provide a summary of their knowledge. Attach a separate sheet of paper if necessary.

5. If you claim that the defendant made any statements or admissions as to the subject matter of this lawsuit, state (a) the date made, (b) the name of the person by whom made, (c) the name and address of the person to whom made, (d) where made, (e) the name and address of each person present at the time the admission was made, and (f) the contents of the admission. If plaintiff made any such statement, provide the information requested in (a), (c), (d), (e), and (f) of this interrogatory. Attach a separate sheet of paper if necessary. If any such statement or admission was made in writing, transcribed or otherwise recorded, attach a copy.

II. PERSONAL INFORMATION

A. Last Name: _____

First Name: _____

Middle Name or Initial: _____

B. Maiden or other names used or by which you have been known and the dates that those names were used:

C. Present Street Address: _____

City	State	Zip Code
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D. Please state all prior addresses where you have lived during the last fifteen years, and dates of residence at each address. Attach a separate sheet of paper if necessary.

Street Address: _____

City	State	Zip Code
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Dates of Residence: _____

Street Address: _____

City State Zip Code

Dates of Residence: _____

Street Address: _____

City State Zip Code

Dates of Residence: _____

E. Please identify each school you have attended (beginning with high school and to the present), dates of attendance, and diplomas or degrees awarded:

F. Please provide your occupation and the name and address of each of your employers for the last (10) years. Use an attached sheet if necessary.

1. Occupation: _____

Employer Name & Address: _____

Dates of Employment: _____

2. Occupation: _____

Employer Name & Address: _____

Dates of Employment: _____

3. Occupation: _____

Employer Name & Address: _____

Dates of Employment: _____

G. Social Security Number: _____

H. Date of Birth: _____

I. Sex: Male _____ Female _____

J. 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 health or physical condition?

Yes _____ No _____

If yes, state what that condition was.

K. Have you ever been rejected from military service for any reasons relating to your health or physical condition?

Yes _____ No _____

If yes, state what the condition was.

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

Yes _____ No _____

If yes, please state:

- 1. Year claim was filed: _____
- 2. Where claim was filed: _____
- 3. Claim/docket number, if applicable: _____
- 4. Nature of disability: _____
- 5. Period of disability: _____

[Attach additional sheets if necessary to describe more than one claim.]

M. Have you ever filed a social security disability claim?

Yes _____ No _____

If yes, please state:

- 1. Year claim was filed: _____
- 2. Where claim was filed: _____
- 3. Nature of disability: _____
- 4. Period of disability: _____

[Attach additional sheets if necessary to describe more than one claim.]

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

Yes _____ No _____

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

O. Have you ever been convicted of a felony within the last 10 years?

Yes _____ No _____

III. FAMILY INFORMATION

A. Are you currently married?

Yes _____ No _____

B. Has your spouse filed a loss of consortium claim?

Yes _____ No _____

C. Spouse's name: _____

D. Spouse's date of birth: _____

E. If you are married or ever have been married, state the beginning and end date(s) of each marriage.

F. Do you have any children?

Yes _____ No _____

If so, please list their name(s), date(s) of birth, and address(es):

IV. MEDICAL CONDITION AND BACKGROUND

A. Do you currently suffer from any physical injuries, illnesses or disabilities?

Yes _____ No _____

B. If the answer is yes, please state the following:

1. Identify the injury, illness, or disability and date of onset:

Injury, illness or disability	Date of onset
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2. By whom first diagnosed:

Name	Address (if not otherwise provided)
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C. Height: _____

D. Weight before use of Pondimin, Redux and/or phentermine: _____

E. Current Weight: _____

F. To the best of your knowledge, have you ever used:

1. Ergotamine preparations (Cafergot)

Yes _____ No _____

If yes, date first taken: _____

Date last taken: _____

2. Any medication for migraine headaches

Yes _____ No _____

If yes, identify the medication: _____

If yes, date first taken: _____

Date last taken: _____

G. Have you used prescription medications (other than Pondimin, Redux and/or phentermine), herbal preparations, or over the counter products to control or reduce your weight?

Yes _____ No _____

If yes, state:

product approx. dates of use

product approx. dates of use

product approx. dates of use

H. Please provide the name and address for each pharmacy where you have obtained prescription medications for the last ten (10) years. Use attached sheets if necessary.

1. Pharmacy Name & Address: _____

2. Pharmacy Name & Address: _____

3. Pharmacy Name & Address: _____

I. Smoking history [check whichever is applicable]

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

J. Do you claim any emotional, psychiatric, and/or psychological injury, illness, or condition as a result of your using Diet Drugs?

Yes _____ No _____

If yes, state:

- 1. Whether you have ever consulted with a psychiatrist, psychologist, counselor, social worker, or other mental health provider or undergone psychiatric or psychological examination or treatment and, if so, set forth the names and address of each such person and the condition(s) for which treated.

a.

Name

Address (if not otherwise provided)

Name

Address (if not otherwise provided)

Name

Address (if not otherwise provided)

b. Condition for which treated

When treated

Condition for which treated

When treated

Condition for which treated

When treated

- 2. Whether you have been prescribed any medications in connection with such treatment and, if so, identify each such drug prescribed, the dates of use, and the name and address of each pharmacy where such prescriptions were filled.

a.

Name

Address (if not otherwise provided)

Drug Prescribed

Name

Address (if not otherwise provided)

Drug Prescribed

Name

Address (if not otherwise provided)

Drug Prescribed

- 3. Whether you have experienced or been treated for any emotional, psychiatric, and/or psychological injury, illness, or condition prior to the use of Pondimin, Redux and/or phentermine.

Yes _____ No _____

4. If you have experienced or been treated for any emotional, psychiatric, and/or psychological injury, illness, or condition prior to the use of Pondimin, Redux and/or phentermine, name and address of each person who treated you.

a. _____
Name

Address (if not otherwise provided)

Name

Address (if not otherwise provided)

Name

Address (if not otherwise provided)

b. Condition for which treated

When treated

Condition for which treated

When treated

Condition for which treated

When treated

K. To the best of your knowledge, have you been told by a doctor or any other medical professional, that you have, may have or had any of the following:

- 1. Hypertension or high blood pressure Yes _____ No _____
- 2. Heart Murmur Yes _____ No _____
- 3. Stroke Yes _____ No _____
- 4. Blood clot to the lung (pulmonary embolism) Yes _____ No _____
- 5. Chronic lung disease Yes _____ No _____
- 6. Immune system disease or dysfunction (including AIDS or HIV) Yes _____ No _____
- 7. Rheumatic fever Yes _____ No _____
- 8. Cirrhosis, hepatitis or other liver disease Yes _____ No _____
- 9. Pulmonary hypertension Yes _____ No _____
- 10. Pulmonary venous hypertension Yes _____ No _____
- 11. Primary pulmonary hypertension Yes _____ No _____
- 12. Heart valve prolapse or regurgitation Yes _____ No _____
- 13. Cardiac arrhythmias Yes _____ No _____
- 14. Collagen vascular disease Yes _____ No _____
- 15. Bacterial endocarditis Yes _____ No _____
- 16. Lupus Yes _____ No _____
- 17. Rheumatoid Arthritis Yes _____ No _____
- 18. Connective Tissue Disease Yes _____ No _____
- 19. Other autoimmune disease Yes _____ No _____
If Yes, specify: _____
- 20. Scarlet Fever Yes _____ No _____
- 21. Carcinoid syndrome Yes _____ No _____
- 22. Sleep apnea Yes _____ No _____
- 23. Heart valve lesions Yes _____ No _____
- 24. Heart valve prolapse Yes _____ No _____
- 25. Congenital aortic valve abnormalities, such as Yes _____ No _____

unicuspid, bicuspid or quadricuspid aortic valve, ventricular septal defect associated with aortic regurgitation

- 26. Congenital mitral valve abnormalities, such as parachute valve, cleft of the mitral valve associated with atrial septal defect Yes _____ No _____
- 27. Other congenital abnormality of heart Yes _____ No _____
- 28. Aortic dissection involving the aortic root and/or aortic valve Yes _____ No _____
- 29. Aortic sclerosis Yes _____ No _____
- 30. Aortic root dilation Yes _____ No _____
- 31. Aortic stenosis Yes _____ No _____
- 32. Chordae tendineae rupture or papillary muscle rupture Yes _____ No _____
- 33. Myocardial infraction Yes _____ No _____

L. If you responded yes to any of the above, please identify the condition, the date of onset and state the name of the physician or other medical professional and, if not provided with the list of Medical Providers served pursuant to Case Management Order No. 2 (attached hereto), the address of the physician who made the diagnosis or informed you of the condition.

1. Condition: _____

Onset: _____

Name and address of diagnosing physician or other person:

2. Condition: _____

Onset: _____

Name and address of diagnosing physician or other person:

3. Condition: _____

Onset: _____

Name and address of diagnosing physician or other person:

M. Please indicate whether you have received any of the following treatments:

Heart, lung or other chest surgery Yes _____ No _____

For what condition?

When? _____

Treating physician:

N. To the best of your knowledge, state whether any of the following tests were administered BEFORE your use of Pondimin, Redux and/or phentermine.

- 1. Echocardiogram Yes _____ No _____
- 2. Electrocardiogram Yes _____ No _____
- 3. Cardiac or pulmonary artery catheterization Yes _____ No _____
- 4. Pulmonary function test Yes _____ No _____
- 5. Perfusion lung scan Yes _____ No _____
- 6. Chest x-ray Yes _____ No _____
- 7. Arterial, cardiac or pulmonary angiogram Yes _____ No _____
- 8. Cardiopulmonary or thallium stress test Yes _____ No _____
- 9. Other diagnostic test or imaging of the heart, lungs or pulmonary arteries or arterial pressure Yes _____ No _____

O. For each test for which you answered yes, identify the treating physician and approximate date of the test.

Treating Physician	Approximate date
Treating Physician	Approximate date

P. If an echocardiogram was taken BEFORE your use of Pondimin, Redux and/or phentermine, please attach a copy of the report(s) if not previously provided pursuant to Case Management Order No. 2.

Q. To the best of your knowledge, state which of the following tests was administered AFTER your use of Pondimin, Redux and/or phentermine:

- 1. Echocardiogram Yes _____ No _____
- 2. Electrocardiogram Yes _____ No _____
- 3. Cardiac or pulmonary artery catheterization Yes _____ No _____
- 4. Pulmonary function test Yes _____ No _____
- 5. Perfusion lung scan Yes _____ No _____
- 6. Chest x-ray Yes _____ No _____
- 7. Arterial, cardiac or pulmonary angiogram Yes _____ No _____
- 8. Cardiopulmonary or thallium stress test Yes _____ No _____
- 9. Other diagnostic test or imaging of the heart, lungs or pulmonary arteries or arterial pressure Yes _____ No _____

R. For each test for which you answered yes, identify the treating physician and approximate date on which the test was done.

Treating Physician	Approximate date
Treating Physician	Approximate date
Treating Physician	Approximate date

- S. If an echocardiogram was taken AFTER your use of Pondimin, Redux and/or phentermine, please attach a copy of the report(s) if not previously provided pursuant to Case Management Order No. 2.

V. **DIET DRUG USE**

A. Please provide the following information as to your use of Pondimin, Redux and/or phentermine. Use an attached sheet if necessary.

- 1. The date of each prescription, name of the Diet Drug prescribed, dosage, and name and address of the prescribing physician.

- 2. The date each prescription was filled or refilled, and the name and address of the pharmacy where the prescription was filled or refilled.

- 3. Each date you discontinued using the Diet Drugs and the reason therefor.

- 4. If you resumed the use of the Diet Drugs, each date you resumed using the Diet Drugs after discontinuance, and the reason therefor.

- 5. Whether you signed an informed consent document or any other document before being prescribed or provided the Diet Drugs (if so attach a copy of the executed informed consent document).

- 6. A description of any effects (whether beneficial or adverse) that you experienced as a result of your Diet Drug use

B. If you took phentermine, please state the brand name(s) and manufacturer/distributor of the phentermine product(s) you took, to the extent known to you.²

1. Brand Name: _____

Manufacturer/Distributor _____

2. Brand Name: _____

Manufacturer/Distributor _____

C. If you took phentermine, please check the description of each phentermine product you took.³

- 1. white capsule with blue cap; "Adipex-P" - "37.5" on cap and two dark stripes on body _____
- 2. white caplet with blue spots; 37.5 mg.; "LEMMON" - "99" with center score _____
- 3. Peanut shaped, green tablet imprinted with "S" on both sides; 37.5 mg. _____
- 4. 30 mg.; blue and clear capsule with blue and white beads; imprinted with "BMP 147," "Fastin" and/or "Beecham" _____
- 5. white tablet with blue dots; oval; 37.5 mg. _____

² Applicable only if suing a phentermine manufacturer or distributor.

³ Applicable only if suing a phentermine manufacturer or distributor.

- 6. green round tablet; 8 mg. _____
- 7. orange round tablet; 8 mg. _____
- 8. yellow oblong tablet; 37.5 mg. _____
- 9. black-yellow capsule; 37.5 mg. _____
- 10. black-black capsule; 37.5 mg. _____
- 11. brown-clear capsule; 37.5 mg. _____
- 12. green-clear capsule; 37.5 mg. _____
- 13. red-black capsule; 37.5 mg. _____
- 14. yellow-yellow capsule; 37.5 mg. _____
- 15. yellow-yellow capsule; 30 mg. _____
- 16. green-clear capsule; 30 mg. _____
- 17. brown-clear capsule; 30 mg. _____
- 18. black-black capsule; 30 mg. _____
- 19. blue-clear capsule; 30 mg. _____
- 20. gray-yellow capsule; 15 mg. _____
- 21. yellow-gray capsule; 18.75 mg. imprinted "18.75" _____
- 22. yellow-gray capsule; 15 mg. imprinted "E882" _____
- 23. yellow-yellow capsule; 30 mg.; imprinted "B647" _____
- 24. blue-white gel capsule; "E5000"; 30 mg. _____
- 25. 37.5 mg. tablet with blue dots _____
- 26. Resin; yellow-yellow capsule imprinted with "IONAMIN 30" _____
- 27. Resin; yellow-gray capsule imprinted with "IONAMIN 15" _____
- 28. Hard yellow gel capsule; 30 mg.; "RPC-69" _____
- 29. green-clear gel capsule; 37.5 mg.; imprinted "ABANA" and "217" _____
- 30. black capsule _____
- 31. yellow capsule _____
- 32. yellow-gray capsule _____
- 33. blue-clear capsule _____
- 34. black gel capsule; 30 mg.; imprinted "Zantryl" _____
- 35. Other: _____
Please describe: _____
- 36. I can't remember what the product looked like _____

D. Did you lose weight while on Pondimin, Redux, and/or phentermine?

_____ Yes _____ No

If the answer is yes, state the amount of weight you lost _____ and state the period during which the weight loss was achieved _____

E. Did you gain weight after you stopped using Pondimin, Redux, and/or phentermine?

_____ Yes _____ No

If the answer is yes, state the amount of weight you gained _____ and state the period during which the weight was gained in relation to when you stopped using Pondimin, Redux and/or phentermine _____

F. State your high and low weight over the past ten years.

High _____ lbs. Approximate Date _____

Low _____ lbs. Approximate Date _____

VI. INJURY CLAIMS

A. 1. Have you had discussions with any physician treating you for a cardiac condition or injury which you are claiming was caused by your ingestion of Pondimin, Redux and/or phentermine about whether your condition or injury is related to the use of these diet drugs?

Yes _____ No _____ Don't know _____

2. If yes, check one of the following:

- a. I was told my condition is related to the use of diet drugs. _____
- b. I was told my condition is not related to the use of diet drugs. _____
- c. I was told my condition may be related to the use of diet drugs. _____
- d. I was told by the doctor that he/she does not know whether my condition is related to the use of diet drugs. _____
- e. I don't recall what I was told. _____

3. Identify the doctor or doctors:

Name

Address (if not otherwise provided)

4. If discussed with more than one doctor, please copy and complete Parts 2 and 3 for each.

B. State whether you requested that any doctor or clinic provide you with diet drugs, and, if yes, identify the drug requested.

Yes _____ No _____

If yes, identify the drug requested: _____

C. Were you given any written instructions or warnings regarding the use of Pondimin, Redux and/or phentermine?

Yes _____ No _____

If yes, state when the written instructions or warnings were given and identify each person or entity from whom you received the warnings or instructions.

Approximate date

Name of person or entity (and address if not otherwise provided)

D. Were you given any verbal instructions or warnings regarding the use of Pondimin, Redux and/or phentermine?

Yes _____ No _____

If yes, state when the verbal instructions or warnings were given and identify each person or entity from whom you received the warnings or instructions.

Approximate date

Name of person or entity (and address if not otherwise provided)

E. If you claim or expect to claim that you lost earnings or impairment of earning capacity as a result of any condition which you believe was caused by your use of diet drugs:

1. Complete the following information with respect to your employment for the past ten years.

Employers for Past Ten Years	Address	Type of Business/Position	Dates of Employment

2. State the total amount of time which you have lost from work as a result of any condition which you claim or believe was caused by your use of diet drugs and the amount of income which you lost.

3. State your earned income for each of the last ten years.

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

F. 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 or believe was caused by your use of diet drugs and for which you seek recovery in the action which you filed?

Yes _____ No _____

If yes, state the total amount of such expenses at this time.

_____ \$ _____

VII. DOCUMENTS

Attach the following documents to this declaration, to the extent that such documents are currently in your possession or in the possession of your lawyers (if either the documents or an executed authorization to obtain such documents have not been previously supplied).

A. A copy of all prescriptions for diet medications, exemplars of any unused diet medications you received as a result of such prescriptions, receipts, physician or office records, drug containers, packaging and other records which show each diet drug you have taken, the period during which you

have taken each, the dosage of each diet drug and the frequency with which you took each drug.

- B. A copy of all medical records from any physician, hospital or health provider, who treated you for any disease, condition or symptom referred to in your response to questions in Part IV.
- C. All diagnostic tests or test results including reports of echocardiograms.
- D. Copies of all documents from physicians, health or weight loss clinics or others relating to the use of diet drugs, or to any condition you claim is related to the use of diet drugs.
- E. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, pharmacy handouts or other materials distributed with or provided to you when your prescriptions for diet medications were filled.
- F. Executed authorizations permitting release of records from all pharmacies listed above.
- G. All personal records in your possession regarding weight gain and weight loss efforts.
- H. If you claim you have suffered a loss of earnings or earning capacity, your W-2 and/or 1099 income tax forms 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.
- J. If applicable, a certified copy of the death certificate, and any and all documents, including but not limited to autopsy reports, indicating the cause of death.
- K. If applicable, a copy of all authorizing letters testamentary or letters of administration.

RIDER 1

This section applies only to plaintiffs asserting an Intermediate Opt-Out ("IOO") or a Back-End Opt-Out ("BEOO") pursuant to the Nationwide Class Action Settlement Agreement with American Home Products Corporation (the "Settlement Agreement").

As to each echocardiogram upon which you rely to assert a right to sue pursuant to the IOO or BEOO provisions of the Settlement Agreement, provide the following information:

1. The date the echocardiogram was performed.
2. The name and address of the qualified medical personnel (i.e. sonographer, technician or cardiologist) who performed the echocardiogram, to the extent the information is within your knowledge.
3. The name and address of the employer of the qualified medical personnel (i.e. sonographer, technician or cardiologist at the time the echocardiogram was performed, to the extent this information is within your knowledge.
4. The name and address of the laboratory or company responsible for performing the echocardiogram.
5. The name of the cardiologist who evaluated the echocardiogram, only if this information is not provided elsewhere (e.g. on the echocardiogram videotape or cardiologist's report).
6. The qualifications of the cardiologist who evaluated the echocardiogram including information concerning Board Certification or Board Eligibility.

RIDER 2A

HOSPITAL WORKSHEET

Each plaintiff who is required to complete a Plaintiff Fact Sheet must complete the Hospital Worksheet to the best of their knowledge and recollection.

For each hospital or other medical facility where you have received in-patient and/or outpatient treatment, including emergency room visits, please provide the following information:

Name & Address of Hospital or Medical Facility	Admitted as In-Patient? (Y/N)	Reason for Treatment	Diagnosis of Your Condition, Injury or Illness	Dates of Hospitalization or Out-Patient Visits

Attach additional sheets if needed to provide a complete answer.

RIDER 2B

MEDICAL PROVIDER WORKSHEET

Each plaintiff who is required to complete a Plaintiff Fact Sheet must complete the Medical Provider Worksheet to the best of their recollection and knowledge.

For each physician or medical provider from whom you have received treatment, with whom you have consulted regarding your health, who has examined you, who has performed tests, surgery or other procedures for you, who has prescribed medications to you, or who has otherwise provided medical care to you, please provide the following information:

Provider's Name & Address	Provider's Specialty	Injury, Illness, Condition or Other Reason for Seeing Provider	Dates of Treatment

Attach additional sheets if needed to provide a complete answer.

CERTIFICATION

I hereby certify that the foregoing responses to the Plaintiff's Fact Sheet are true and correct to the best of my knowledge and recollection. I am aware that if any of the foregoing is willfully false, I may be subject to punishment.

Signature