



2. Address \_\_\_\_\_
3. In what capacity you are representing the individual \_\_\_\_\_
4. If you were appointed by a court, state the court & date of appointment \_\_\_\_\_
5. Your relationship to deceased or represented person \_\_\_\_\_
6. If you represent a decedent's estate, state the date of death of decedent \_\_\_\_\_

**I. Personal Data**

- a. Name: \_\_\_\_\_
- b. Any other names used and dates of use: \_\_\_\_\_
- c. Address: \_\_\_\_\_
- d. Date when began living at current address: \_\_\_\_\_
- e. All prior addresses during last ten years: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- f. Social Security Number: \_\_\_\_\_
- g. Date and place of birth: \_\_\_\_\_
- h. Date of Death, if applicable: \_\_\_\_\_
- i. Marital Status: \_\_\_\_\_
- j. Name(s) of current and former spouse(s) and date(s) of marriage(s), if applicable:  
\_\_\_\_\_  
\_\_\_\_\_
- k. Name(s) and date(s) of birth of children, if applicable:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

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

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

- 
- (i) Name: \_\_\_\_\_
  - (ii) Address: \_\_\_\_\_

- (iii) Duties: \_\_\_\_\_
  - (iv) Job title: \_\_\_\_\_
  - (v) Dates Employed: \_\_\_\_\_
  - (vi) Full-time or Part-time: \_\_\_\_\_
  - (vii) Are you making a wage loss claim? \_\_\_\_ Yes \_\_\_\_ No  
If "yes," state your annual income:
  - (viii) Did you leave the job for a medical reason? \_\_\_\_ Yes \_\_\_\_ No  
If "yes," describe why you left that job:
  - (ix) Name of Supervisor: \_\_\_\_\_
  - (x) Identify any claims or suits brought against employer: \_\_\_\_\_
- 

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

(i) High School

- (a) Name:
- (b) Address:
- (c) Grade completed:
- (d) Year graduated:

(ii) did you attend school beyond high school? \_\_\_\_ Yes \_\_\_\_ No

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

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

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

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

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

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

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

- (i) Date (or year) of application:
- (ii) Type of benefits:

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

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

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

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**II. Health Care Providers**

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

- (i) Name: \_\_\_\_\_
- (ii) Specialty, if any: \_\_\_\_\_
- (iii) Address: \_\_\_\_\_
- (iv) Phone: \_\_\_\_\_
- (v) Reason(s) for Visit(s): \_\_\_\_\_

(vi) Medications prescribed or recommended by provider: \_\_\_\_\_

- (i) Name: \_\_\_\_\_
- (ii) Specialty, if any: \_\_\_\_\_
- (iii) Address: \_\_\_\_\_
- (iv) Phone: \_\_\_\_\_
- (v) Reason(s) for Visit(s): \_\_\_\_\_

(vi) Medications prescribed or recommended by provider: \_\_\_\_\_

- (i) Name: \_\_\_\_\_
- (ii) Specialty, if any: \_\_\_\_\_
- (iii) Address: \_\_\_\_\_
- (iv) Phone: \_\_\_\_\_
- (v) Reason(s) for Visit(s): \_\_\_\_\_

(vi) Medications prescribed or recommended by provider: \_\_\_\_\_

- (i) Name: \_\_\_\_\_
- (ii) Specialty, if any: \_\_\_\_\_

- (iii) Address: \_\_\_\_\_
- (iv) Phone: \_\_\_\_\_
- (v) Reason(s) for Visit(s): \_\_\_\_\_

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(vi) Medications prescribed or recommended by provider: \_\_\_\_\_

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- (i) Name: \_\_\_\_\_
- (ii) Specialty, if any: \_\_\_\_\_
- (iii) Address: \_\_\_\_\_
- (iv) Phone: \_\_\_\_\_
- (v) Reason(s) for Visit(s): \_\_\_\_\_

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(vi) Medications prescribed or recommended by provider: \_\_\_\_\_

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\*Please attach additional pages if necessary

b. For each hospitalization that you have undergone in the last fifteen (15) years, state:

- (i) Name: \_\_\_\_\_
- (ii) Address: \_\_\_\_\_
- (iii) Phone: \_\_\_\_\_
- (iv) Reason(s) for Hospitalization(s): \_\_\_\_\_

- 
- (i) Name: \_\_\_\_\_
  - (ii) Address: \_\_\_\_\_
  - (iii) Phone: \_\_\_\_\_
  - (iv) Reason(s) for Hospitalization(s): \_\_\_\_\_
- 

- 
- (i) Name: \_\_\_\_\_
  - (ii) Address: \_\_\_\_\_
  - (iii) Phone: \_\_\_\_\_
  - (iv) Reason(s) for Hospitalization(s): \_\_\_\_\_
- 

\*Please attach additional pages if necessary.

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

- (i) Name of operation: \_\_\_\_\_
- (ii) Name of surgeon: \_\_\_\_\_

- (iii) Address of surgeon \_\_\_\_\_
- (iv) Reason for surgery \_\_\_\_\_

d. Have you ever consulted a physician or a clinic facility regarding any gastrointestinal condition or disease including but not limited to heartburn, ulcers, gastroenteritis, bleeding, pain? If yes, state:

- (i) Name of doctor or facility \_\_\_\_\_
- (ii) Address \_\_\_\_\_
- (iii) Date \_\_\_\_\_
- (iv) Diagnosis \_\_\_\_\_
- (v) Treatment \_\_\_\_\_
- (vi) Medications \_\_\_\_\_
- (vii) Did condition resolve? \_\_\_\_\_
- (viii) Current status of condition \_\_\_\_\_

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

- (i) Electrocardiogram [EKG/ECG] \_\_\_\_\_
- (ii) Cardiac Catheterization \_\_\_\_\_
- (iii) Exercise Stress Test \_\_\_\_\_
- (iv) Holter Monitor \_\_\_\_\_
- (v) Thallium Scan \_\_\_\_\_
- (vi) Echocardiogram \_\_\_\_\_
- (vii) Other diagnostic test of heart, lungs or cardiopulmonary blood vessels \_\_\_\_\_

If yes, please state separately for each:

- (i) Type of test \_\_\_\_\_
- (ii) Date administered \_\_\_\_\_
- (iii) Reason for test \_\_\_\_\_
- (iv) Facility name and address \_\_\_\_\_
- (v) Ordering doctor \_\_\_\_\_
- (vi) Results/diagnosis \_\_\_\_\_
- (vii) Treatment \_\_\_\_\_

If yes, please state separately for each:

- (i) Type of test \_\_\_\_\_
- (ii) Date administered \_\_\_\_\_
- (iii) Reason for test \_\_\_\_\_
- (iv) Facility name and address \_\_\_\_\_
- (v) Ordering doctor \_\_\_\_\_
- (vi) Results/diagnosis \_\_\_\_\_

(vii) Treatment \_\_\_\_\_

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

(i) Upper GI Series \_\_\_\_\_

(ii) Barium Swallow \_\_\_\_\_

(iii) Esophagram \_\_\_\_\_

(iv) Small bowel x-ray \_\_\_\_\_

(v) Esophagoscopy \_\_\_\_\_

(vi) Endoscopy \_\_\_\_\_

(vii) Gastroscopy \_\_\_\_\_

(viii) Colonoscopy \_\_\_\_\_

(ix) Other diagnostic test or imaging of the gastrointestinal tract \_\_\_\_\_

If yes, please state separately for each:

(i) Type of test \_\_\_\_\_

(ii) Date administered \_\_\_\_\_

(iii) Reason for test \_\_\_\_\_

(iv) Facility name and address \_\_\_\_\_

(v) Ordering doctor \_\_\_\_\_

(vi) Results/diagnosis \_\_\_\_\_

(vii) Treatment \_\_\_\_\_

### III. Medical Background

a. Height: \_\_\_\_\_

b. Weight \_\_\_\_\_

c. Smoking History

1. never smoked cigarettes \_\_\_\_\_

2. past smoker of cigarettes \_\_\_\_\_

date on which smoking ceased \_\_\_\_\_

Amount smoked: \_\_\_\_\_ packs per day for \_\_\_\_\_ years

3. current smoker of cigarettes

Amount smoked: \_\_\_\_\_ packs per day for \_\_\_\_\_ years

### IV. Propulsid®

a. Have you ever taken Propulsid®? \_\_\_\_\_ Yes \_\_\_\_\_ No

- b. If "yes," then separately state or identify:
- (i) dosage(s):
  - (ii) date(s) of use:
  - (iii) the healthcare provider(s), who prescribed Propulsid® to you:
  - (iv) person(s) or source from which you obtained Propulsid®
  - (v) reason you understood you were prescribed Propulsid®
- c. Did you receive any written or verbal information about Propulsid® before you took it?  
 Yes  No
- d. Did you receive any written or verbal information about Propulsid® while you took it?  
 Yes  No

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

- (i) when you received that information;
  - (ii) from whom you received it;
  - (iii) what information you received;
- e. Please describe any documents, including invoices, package inserts, and literature that you received regarding Propulsid® or that you read before or while you took Propulsid®.

**V. Injuries, Symptoms, Diagnoses, Ailments & Damages**

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

If "yes," then for each such condition, separately state:

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

If "yes" to subpart (v) then, as to each healthcare provider, state:

- (A) the healthcare provider's name;
- (B) the healthcare provider's address;
- (C) the date of first consultation with that healthcare provider;
- (D) date of last consultation;
- (E) do you plan to continue to consult with that healthcare provider?  
 Yes  No

- b. Has any healthcare provider told you, verbally or in writing, that any of these conditions are due to your use of any of Propulsid®?  
       \_\_\_\_\_ Yes \_\_\_\_\_ No

If "yes," then state and describe:

- (i) what you were told;
- (ii) who told you and when;

- c. Are you claiming that you have paid or will have to pay any monetary expenses or fees as a result of having taken Propulsid®?  
       \_\_\_\_\_ Yes \_\_\_\_\_ No

If "yes," then for each item separately identify:

- (i) for what;
- (ii) amount of fees or expenses;
- (iii) person or company paid or to be paid.

- d. Other than those previously identified, are you claiming that you have any other injuries or damages as a result of taking Propulsid®?  
       \_\_\_\_\_ Yes \_\_\_\_\_ No

If "yes," then describe them:

**VI. Other Medications, Supplements, Or Drugs**

Please review the following list of medications and indicate (by checking “yes” or “no”) whether you ever took the medication during a time when you were taking Propulsid. If yes, please indicate dates taken and prescribing doctor under comments section.

	<u>YES</u>	<u>NO</u>	<u>IF YES, DATES TAKEN, PRESCRIBING DOCTOR</u>	<u>NAME AND ADDRESS OF PHARMACY WHERE OBTAINED</u>
<u>ANTI-INFECTIVE DRUGS:</u>				
Biaxin [Clarithromycin]	_____	_____	_____	_____
Cipro [Ciprofloxacin]	_____	_____	_____	_____
Crixivan [Indinavir]	_____	_____	_____	_____
Diflucan [Fluconazole]	_____	_____	_____	_____
Erythrocin & others [Erythromycin]	_____	_____	_____	_____
Flagyl [Metronidazole]	_____	_____	_____	_____
Keflex [Cephalexin]	_____	_____	_____	_____
Nizoral [Ketoconazole]	_____	_____	_____	_____
Norvir [Ritonavir]	_____	_____	_____	_____
Sporanox [Itraconazole]	_____	_____	_____	_____
TAO [Troleandomycin]	_____	_____	_____	_____
Zagam [Sparfloxacin]	_____	_____	_____	_____

ANTIDEPRESSANTS:

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

CARDIOVASCULAR DRUGS:

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

CENTRAL NERVOUS SYSTEM DEPRESSANTS:

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

OTHER:

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

**VII. Family History**

1. Are you aware of any child, parent, sibling, aunt, uncle, or grandparent having suffered from any type of heart disease including but not limited to: abnormal rhythm, arteriosclerosis (hardening of the arteries), murmur, coronary artery disease, congestive heart failure, enlarged heart, leaking valves or prolapse, heart block, congenital heart abnormality, Scarlet Fever, Rheumatic Fever, atrial fibrillation?  
yes \_\_\_\_\_ no \_\_\_\_\_

2. If yes, then state separately for each:  
relationship to you \_\_\_\_\_  
type of heart problem \_\_\_\_\_  
date and cause of death if applicable \_\_\_\_\_

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

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

Date:

\_\_\_\_\_

signature