SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: MIDDLESEX COUNTY

IN RE: FOSAMAX LITIGATION	)	
CASE NO. 282	)	
CIVIL ACTION	)	**Plaintiff: _____**
	)	**Docket No.: _____**

PLAINTIFF PROFILE FORM

Please provide the following information regarding yourself or each individual on whose behalf a personal injury claim is being made. Each question must be answered in full. If you do not know or cannot recall the information needed to answer a question, please indicate that in response to the question. To the extent you cannot completely answer any question, please provide whatever information is available to you and, as to any information sought by the question which you do not know, please identify what part of the question you cannot answer. Do not leave any questions unanswered or blank.

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

In filling out this form, please use the following definitions:

(1) "**health care provider**" or "**health care practitioner**" means any hospital, clinic, center, physician's office, dentist's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dental, oral, psychiatric, mental, emotional or psychological care or advice, and any doctor, physician, surgeon, oncologist, radiologist, dentist, oral and maxillofacial surgeon pathologist, oral pathologist, natural health provider, homeopath, osteopath, chiropractor, paramedic, nurse (registered or otherwise), physiotherapist, psychologist, psychiatrist, therapist, or any other person practicing any healing art, or performing any physical, dental, oral, radiological, or mental evaluation or examination or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you;

(2) "**document**" means any writing or record of every type that is in your possession or the possession of your counsel, including but not limited to written documents, e-mails, cassettes, videotapes, photographs, charts, computer discs or tapes, x-rays, drawings, graphs, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into any reasonably usable form.

(3) "**Fosamax**" means FOSAMAX® and FOSAMAX PLUS D®.

(4) "**Osteonecrosis of the jaw**" includes "avascular necrosis of the jaw," "aseptic necrosis of the jaw," and "ischemic necrosis of the jaw."

Other than in Section I(C), those questions using the term "You" should refer to the person who used Fosamax. You should attach as many sheets of paper as necessary to fully answer these questions.

If you have any documents (as defined above), that you are requested to produce in response to questions in this profile form or that relate to Fosamax or other bisphosphonate-containing products or medications you allegedly took, or to the incident, injuries, claims or damages that are the subject of your complaint or, if you have any unused Fosamax and its accompanying packaging, you are required to give all of these documents and materials to your attorney as soon as possible. If you are unclear about this obligation, please contact your attorney.

Whenever you are asked for the name and address of an individual or entity, you are to provide the full name and complete address for that individual or entity.

I. CASE INFORMATION

A. Name of person completing this form: _____.

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

1. Case Caption:

_____

2. Docket No.:

_____

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

_____

Name of attorney

_____

Firm name

_____

City, State and Zip Code

_____

Telephone number

C. If you are completing this questionnaire on behalf of someone else (*e.g.*, a deceased person, an incapacitated person), please complete the following:

_____

Your Name

_____

Address

_____

Social Security Number

_____

In what capacity are you representing the individual? _____

_____

If you were appointed by a court, please provide a copy of the order of appointment or power of attorney/authorizing document and state the:

_____

Court Date of Appointment

What is your relationship to the deceased or represented person?_____

_____

If you represent a decedent's estate, state the date of the decedent's death:_____

D. Claim Information

1. Do you claim that you have suffered a physical injury as a result of Fosamax use? Yes _____ No _____

2. If the answer to the foregoing question is "yes," state the nature of the physical injury or injuries which you claim.
___ Osteonecrosis of the Jaw
___ Osteomyelitis of the Jaw
___ Increased Risk of Developing Osteonecrosis of the Jaw
___ Other (Please Specify): _____
___ Not claiming any physical injuries as a result of Fosamax use
a. When do you claim this injury occurred? _____
(month/day/year)

b. Date of diagnosis: _____
(month/day/year)

c. Name, address, telephone number and specialty of the person who diagnosed this injury:
_____
_____
_____
_____

d. Name, address, telephone number and specialty of the person who treated this injury:
_____
_____
_____
_____

3. Do you claim that you have suffered a psychological or emotional injury as a result of Fosamax use? Yes _____ No_____

4. If the answer to the foregoing question is "yes," state the nature of the psychological or emotional injury or injuries, which you claim.
____ Depression
____ Anxiety

____ Other (Please Specify):

_____

_____

___ Not claiming any psychological or emotional injury as a result of Fosamax use

a. When do you claim this injury occurred?_____
(month/day/year)

b. Have you sought treatment for this psychological or emotional injury? Yes ____ No ____

c. Symptom(s): _____

d. Date(s) of onset: _____

e. Date of diagnosis: _____
(month/day/year)

f. Do you still have the injury? Yes ____ No ____

g. Name, address, telephone number and specialty of the person who first diagnosed this injury.

_____

_____

h. Name, address, telephone number and specialty of the person who treated this injury:

_____

_____

i. Medications prescribed or recommended: _____

_____

_____

j. Date(s) of treatment:

_____

_____

5. Have you had discussions with any physician(s), dentist(s), or other health care provider(s) about whether any injury described in section I(D) above is related to the use of Fosamax?

Yes _____No _____ Don't Recall ____

If "yes," please identify:
Name(s) of health care provider(s): _____
Address(es):_____
Specialty:_____
Date(s) of Discussion(s):

_____

a. Do you recall what you were told? Yes ____ No____ Don't Recall _____

b. **If "yes,"** what were you told?

_____

[If you discussed with more than one health care provider, please separately identify what each individual said to you]

6. Do you claim that your treatment with Fosamax increased your risk of a future injury or harm that you have not yet experienced?
Yes _____ No _____

If "yes," identify and describe each and every such future injury or harm and for each, identify the basis for your contention.

_____
_____
_____
_____
_____
_____
_____

7. Have you had any discussions with any physician(s), dentist(s), or other health care provider(s) about whether your treatment with Fosamax or any other bisphosphonate puts you at increased risk of future injury or harm?
Yes_____ No_____ Don't Recall _____

If "yes," please identify:
Name of heath care provider(s):_____
Address:_____
Specialty:_____
Date(s) of Discussion(s):_____
State what the health care provider told you, including any description of the future injury or harm: _____

[If you discussed with more than one health care provider, please separately identify what each individual said to you]

8. If you do not claim to have suffered a physical, psychological, or emotional injury as a result of Fosamax use, state how you have been injured or damaged.

_____

II. PERSONAL INFORMATION OF THE PERSON WHO USED FOSAMAX

A. Name: _____

B. Maiden name(s) or any other name(s) by which you have been known (from prior marriages or otherwise, if any):_____

C. Gender: Male _____ Female _____

D. Social Security number: _____

E. Driver's license number: _____
State of issuance:_____

F. Date and place of birth (city, county, and state):

_____

G. Provide the full name, address, and age of each of your children: _____

_____
_____
_____

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

Address	**Dates of Residence**

I. Complete the following information with respect to your employment for ten (10) years prior to your use of Fosamax or any other bisphosphonate to the present (If not employed during that period, state last employer).

Employer	**Address**	**Occupation/ Job Duties**	**Dates of Employment**	**Salary/ Bonus/ Overtime**

J. Within the last ten (10) years, have you been convicted of any felony or a crime involving dishonesty or false statement?
Yes _____ No _____

If "yes," please (1) identify the crime and/or felony, (2) when you were convicted or pled guilty, (3) where you were convicted or pled guilty, (4) whether you were incarcerated, and if so, for how long you were incarcerated.

_____
_____
_____

K. Are you making a claim for lost wages for either your present or previous employment? Yes _____ No _____
If "yes," identify your annual income at the time of the injury alleged in Section I(D):_____

L. Have you ever filed a lawsuit or brought any other type of legal claim aside from the present suit? Yes _____ No _____

If "yes," for each such lawsuit, state (1) the court in which such lawsuit was filed, (2) the case name, (3) the names of the adverse parties, (4) the civil action or docket number assigned to the lawsuit, (5) a description of your claims in the lawsuit, and (6) whether the lawsuit has been resolved and if so, how it was resolved._____
_____
_____
_____

M. 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? Yes ____ No ____
   If **"yes,"** state what that condition was:_____
   _____
3. Have you ever been rejected from military service for any reason relating to your health or physical condition? Yes ____ No ____
   If **"yes,"** state what that condition was:_____
   _____
4. Have you ever served in the military overseas? Yes ____ No ____
   If **"yes,"** state location and dates:_____
   _____

N. Insurance / Claim Information

1. Have you ever filed a worker's compensation claim? Yes ___ No ___

   If "yes," to the best of your knowledge please state:

   a. Year claim was filed: _____
   b. Nature of disability: _____
   c. Approximate dates of disability: _____
   d. Resolution of claim: Denied ____ Granted ____ Other ____
      If "other," describe: _____
   e. Identify the full name and address of the entity most likely to have records concerning your claim: _____

f. Full name and address of your employer against whom claim was filed:_____

_____

2. Have you ever filed a social security disability (SSI or SSD) claim? Yes ____ No ____

If "yes," to the best of your knowledge please state:

a. Year claim was filed: _____

b. Nature of disability: _____

c. Approximate dates of disability: _____

d. Resolution of claim: Denied ____ Granted ____ Other ____
If "other," describe: _____

e. Identify the full name and address of the entity most like to have records concerning your claim:

_____

_____

3. Has any insurance or other company provided medical and/or dental coverage to you (either directly or through a group or employer) for the period beginning twelve (12) years before your first use of Fosamax or any other bisphosphonate through the present? Yes_____ No _____ Don't Recall _____

If "yes," then as to each such company, separately state:

a. Name of the company:

b. Address of the company:

_____

_____

c. The account/policy number or designation: _____

d. Name of Primary Insured: _____

e. Dates of coverage: _____

a. Name of the company

b. Address of the company:

_____

_____

c. The account/policy number or designation:_____

d. Name of Primary Insured: _____

e. Dates of coverage: _____

f. If there is any insurance coverage for which you cannot recall all of the details, please describe those details that you can remember:

_____

_____

_____

III. EDUCATIONAL HISTORY

Identify each school, college, university and other educational institution you have attended, the dates of attendance, courses of study pursued and diplomas or degrees awarded._____

_____

IV. FAMILY INFORMATION

A. Have you ever been married?
Yes _____ No _____

B. **If "yes,"** for each spouse/former spouse state:

1. Spouse's name: _____
2. Dates of marriage:_____
3. Spouse's date of birth: _____
4. Spouse's occupation: _____
5. Spouse's address and phone number: _____

   _____
6. If applicable, why did the marriage end (*e.g.*, divorce, death)? _____
7. If applicable, the date the marriage ended: _____

C. Have your grandparents, parents, siblings and children ever had or been diagnosed with or had osteonecrosis or osteomyelitis?
Yes _____ No_____

If "yes," state (1) the name and relationship of the person to you, (2) the disease(s) he or she has/had, and (3) the date of that individual's diagnosis. ___

_____

_____

V. DENTAL BACKGROUND FOR JAW RELATED INJURY CLAIMS

Please complete this section if you are claiming any jaw-related injury or you are claiming that you are at risk of any future jaw-related injury. If you are not claiming any such injury, please complete Section V (alternate) beginning on p. 13 below.

A. HABITS

1. On average, during the twelve (12) year period BEFORE you first used Fosamax, how often did you:

a. Brush your teeth per week? _____

b. Floss your teeth per week? _____

c. See a dentist for routine check-ups, examinations or teeth cleaning? _____

_____

2. On average, during the period AFTER you began using Fosamax, how often do you:

a. Brush your teeth per week? _____

b. Floss your teeth per week? _____

c. See a dentist for routine check-ups, examinations or teeth cleaning? _____

_____

B. DENTAL STATUS

1. Are you missing any teeth (including wisdom teeth or others)?
Yes _____ No _____ Don't Recall _____
If "yes," indicate the following:
a. How many are you missing? _____
b. Which teeth? _____
c. When and how did you lose each of those teeth? _____
_____

2. Were any of the missing teeth extracted? Yes _____ No _____ Don't Recall _____

If "yes," indicate the following:
a. How many? _____
b. Which teeth? _____
_____
c. When and why were these teeth extracted? _____
_____
d. Who performed each extraction? (please provide the name, address, telephone number and specialty of the person who performed each extraction(s)). _____
_____
_____

3. Have you ever had any dental implants, artificial fixtures (including dentures and bridges), or any dental prosthodontics or orthodontia (including braces)? Yes _____ No _____ Don't Recall _____

If "yes," indicate the following:
a. What type of dental implant(s), artificial fixture(s), or dental prosthodontics or orthodontia did you have? _____
_____

_____

b. Identify approximately when you received each dental implant, artificial fixture, or dental prosthodontics or orthodontia? _____
_____
_____

c. Please identify the teeth or the approximate locations in your mouth where you received dental implants, artificial fixtures, or dental prosthodontics or orthodontia? _____
_____
_____

d. Please provide the name, address, telephone number and specialty of the persons who installed or fitted your dental implants, artificial fixtures, or dental prosthodontics or orthodontia. _____
_____
_____
_____

e. Please describe any problems or complications you experienced relating to the dental implants, artificial fixtures, or dental prosthodontics or orthodontia you received? _____
_____
_____

4. Have you ever had any periodontal procedures? Yes ____ No _____ Don't Recall _____

If "yes," indicate the following:

a. What type of periodontal procedure(s) have you had? _____
_____

b. When did you receive each procedure? _____

c. Please provide the name, address, telephone number and specialty of the person who performed each procedure. _____
_____
_____

d. Did you have any problems or complications related to the periodontal procedure (describe each complication)? _____
_____
_____

5. Have you ever had a fracture of the jaw? Yes ____ No _____ Don't Recall _____

If "yes," indicate the following:

a. Date(s) of each fracture?_____

b. Describe how you suffered each fracture?_____

_____

c. Describe the portion(s) of the jaw fractured and the extent of the fracture(s):_____

_____

d. Please provide the name, address, and telephone number of each person who treated you for each fracture. _____

_____

C. Have you ever had or been diagnosed with any of the following conditions:

	Yes	No	Unknown
Osteonecrosis of the jaw			
Osteomyelitis			
Infection in the mouth			
Tori in the mouth			
Bone spurs in the mouth			
Exposed bone in the mouth			
Tooth decay			
Poor healing of infections in the mouth			
Gum disease or infection			
Periodontal disease			
Bleeding gums			
Temporomandibular joint [TMJ] problems			
Abscesses			
Lesions in the mouth			
Cancer of the mouth			
Herpes [in or around the mouth]			
Lockjaw			
Exostosis (bony outgrowth)			
Pain (persistent or otherwise) in the mouth or jaw			
Swelling in the mouth or jaw			
Non-healing sore in the mouth or jaw			
Draining fistula			
Numbness of the lip, chin, mouth or jaw			
"Heaviness" of the jaw			
Burning or tingling in the jaw			
Limited range of motion in the jaw			
Edentulous (toothless) regions in the mouth			
Lingual Mandibular Sequestration			
Osteoradionecrosis			
Other disease of the jaw or oral cavity Please specify: _____			

D. If you responded "**yes**" to any of the above, please provide the following information for each condition:

Condition	Name and Address of Person(s) Who Diagnosed or Treated the Condition	Approximate Onset Date of

		Condition

E. State whether you ever had any of the following dental or oral procedures/tests at any time.

	Yes	No	Unknown
Gingivectomy or gum resection			
Periodontal surgery			
Oral surgery			
Root canal or other endodontic procedure			
Root planing, scaling, or other treatment for gum disease			
Any invasive dental procedure			
Ridge smoothing			
Debridement of the oral cavity			
Bone trimming			
Apicoectomy			
Bone jaw biopsy			
Dental x-rays, panorexes, or other dental imaging			
Other diagnostic test or imaging of the mouth or jaw Please specify: _____			

F. For each procedure/test for which you answered "yes," please identify the following information:

Test/Procedure	Name and Address of Physician/Dentist Who Performed Test/Procedure	Approximate Dates of Treatment

V (ALT). DENTAL BACKGROUND FOR NON-JAW RELATED INJURY CLAIMS

Complete this section (Section V (alt.)) only if you did not complete Section V above.

A. DENTAL STATUS

1. Are you missing any teeth (including wisdom teeth or others)?
   Yes _____ No _____ Don't Recall _____
   If "yes," indicate the following:
   a. How many are you missing? _____
   b. Which teeth? _____
   c. When and how did you lose each of those teeth? _____
   _____

2. Were any of the missing teeth extracted? Yes _____ No _____ Don't Recall _____

If "yes," indicate the following:

a. How many? _____

b. Which teeth? _____

_____

c. When and why were these teeth extracted? _____

_____

d. Who performed each extraction? (please provide the name, address, telephone number and specialty of the person who performed each extraction(s)). _____

_____

_____

3. Have you ever had any dental implants, artificial fixtures (including dentures and bridges), or any dental prosthodontics or orthodontia (including braces)? Yes _____ No _____ Don't Recall _____

If "yes," indicate the following:

a. What type of dental implant(s), artificial fixture(s), or dental prosthodontics or orthodontia did you have? _____

_____

_____

b. Identify approximately when you received each dental implant, artificial fixture, or dental prosthodontics or orthodontia? _____

_____

_____

c. Please identify the teeth or the approximate locations in your mouth where you received dental implants, artificial fixtures, or dental prosthodontics or orthodontia? _____

_____

_____

d. Please provide the name, address, telephone number and specialty of the persons who installed or fitted your dental implants, artificial fixtures, or dental prosthodontics or orthodontia. _____

_____

_____

_____

e. Please describe any problems or complications you experienced relating to the dental implants, artificial fixtures, or dental prosthodontics or orthodontia you received? _____

_____

4. Have you ever had any periodontal procedures? Yes ____ No ____ Don't Recall _____

If "yes," indicate the following:

a. What type of periodontal procedure(s) have you had? _____

b. When did you receive each procedure? _____

c. Please provide the name, address, telephone number and specialty of the person who performed each procedure. _____

d. Did you have any problems or complications related to the periodontal procedure (describe each complication)? _____

5. Have you ever had a fracture of the jaw? Yes ____ No ____ Don't Recall _____

If "yes," indicate the following:

a. Date(s) of each fracture?_____

b. Describe how you suffered each fracture?_____

c. Describe the portion(s) of the jaw fractured and the extent of the fracture(s):_____

d. Please provide the name, address, and telephone number of each person who treated you for each fracture. _____

B. State whether you ever had any of the following dental or oral procedures, treatments, or tests at any time.

	Yes	**No**	**Unknown**
Gingivectomy or gum resection			
Periodontal surgery			
Oral surgery			
Root canal or other endodontic procedure			
Root planing, scaling, or other treatment for gum disease			
Any invasive dental procedure			
Ridge smoothing			
Debridement of the oral cavity			
Bone trimming			
Apicoectomy			
Bone jaw biopsy			
Intravenous antibiotics to treat a dental infection			

C. For each procedure/test for which you answered "yes," please identify the following information:

Test/Procedure	Name and Address of Physician/Dentist Who Performed Test/Procedure	Approximate Dates of Treatment

D. If you claim to have suffered a femur fracture as a result of your use of Fosamax, please complete this section:

1. For each fracture identified in Section I.D., please state:

   a. Location of fracture:
   _____
   _____

   b. Activity when fracture occurred:
   _____
   _____

   c. Treatment and/or therapy received following the fracture (including but not limited to surgeries, prophylactic rodding, pinning, physical therapy, medications etc.):
   _____
   _____
   _____

   d. Whether you encountered any healing or recovery problems following the fracture and the nature of the problems encountered (non-union fracture, non-healing fracture, etc.):
   _____
   _____

   e. Whether you experienced any hip, leg, or groin pain prior to your fracture and, if so, please describe the pain, its severity, its location, and its duration: _____
   _____
   _____

f. If you experienced pain described in subsection (e) above, describe any activities or treatments that increased or decreased the pain:_____
_____
_____
_____

2. For each imaging test or procedure you have ever had on or around your leg, hip, or groin in the past 20 years, set forth, to the best of your knowledge, the date, the type of imaging test or procedure performed (I.e., x-ray, MRI, CT, bone scan, or any other imaging), the physician who requested that you have the imaging, and the physician or group that performed the imaging.

Type of Test or Procedure (i.e., x-ray, MRI, CT, bone scan, or other imaging)	**Name and Address of Physician Who Requested the Test or Procedure**	**Name and Address of Physician Who Performed the Test or Procedure**	**Date of the Test or Procedure**

3. Other than fractures described in Section I.D. and Section V (alt.) 1. have you suffered any other prior fractures? Yes_____ No_____ Don't Recall_____

If "yes," indicate the following:

a. Date of fracture: _____

b. Location of fracture: _____

c. Circumstances surrounding the fracture: _____
_____

d. Treatment and/or therapy received following the fracture:
_____
_____

e. Whether you encountered any healing or recovery problems following the fracture and the nature of the problems encountered: _____
_____
_____

f. Whether you experienced any pain prior to your fracture and, if so, please describe the pain, its severity, its location, and its duration:

_____
_____
_____

4. In the past 20 years, have you taken any vitamins or other dietary supplements? Yes_____ No_____ Don't Recall _____

If "yes," indicate the following:

a. Type: _____
_____
_____
_____

b. Period of Use: _____
_____
_____
_____

c. Dosage: _____
_____
_____
_____

d. Name and address of the physician, if any, who recommended them: _____
_____
_____
_____

5. To the best of your knowledge, have you used or taken any of the following medications or substances in the past 20 years? If "yes," please provide the first and last date on which you took the medication or substance.

	Yes	**No**	**Unknown**	**Date First Taken**
Proton pump inhibitors (i.e., omeprazole (brand names: Losec, Prilosec, Zegerid, Ocid, Lomac, Omepral, Omez)				
Lansoprazole (i.e., brand names: Prevacid, Zoton, Inhibitol, Levant, Lupizole)				
Dexlansoprazole (i.e., brand names: Kapidex, Dexilant)				
Esomeprazole (i.e., brand names: Protonix, Somac, Pantoloc, Pantozol, Zurcal, Pan)				

Rabeprazole (i.e., brand names: Zechin, Rabecid, AcipHex, Pariet, Rabeloc)				
Dorafem				

If you responded "**yes**" to any of the above, please provide the name and address of the physician who prescribed the medication and the approximate dates of use in the chart below:

Name of Medication or Substance	**Name and Address of Physician who Prescribed the Medication**	**Approximate Dates of Use**

6. Have you ever experienced or been diagnosed or treated for any of the following:

	Yes	**No**	**Unknown**
Hypophosphatasia			
Osteopetrosis (also known as marble or ivory bone disease, Albers-Schonberg disease, and generalized congenital osteosclerosis)			
Osteomalacia (also known as adult rickets)			
Dyspepsia			
Peptic ulcer disease			
Gastroesophageal reflux disease			
Barrett's esophagus			
Gastritis			
Gastimona			
Vitamin D deficiency			
Vitamin D insufficiency			
Calcium deficiency			
Calcium insufficiency			

If you responded "**yes**" to any of the above, please provide the following information for each condition:

Condition	**Name and Address of Person(s) Who Diagnosed or Treated Condition**	**Approximate Onset Date of Condition**

7. To the best of your knowledge, state whether you underwent any of the following test or procedures at any time:

	Yes	No	Unknown
Bone mineral density			
Calcium levels			
Vitamin levels			
Serum total alkaline phosphatase			
Serum bone-specific alkaline phosphatase (BSAP)			
Serum osteocalcin			
Serum type 1 procallagen (C1NP or P1NP)			
Urinary hydroxyproline			
Urinary total pyridinoline (PYD)			
Urinary free deoxypyridinoline (DPD)			
Urinary collagen type 1 cross-linked N-telopeptide (NTX)			
Urinary or serum collagen type 1 cross-linked C-telopeptide (CTX)			
Bone sialoprotein (BSP)			
Tartrate-resistant acid phosphatase 5b			
Other bone turnover markers test (please specify):			

For each test or procedure for which you answered "**yes**," please identify the physician who ordered the test or procedure, the location where the test or procedure was performed, and approximate date of the test.

Test/ Procedure	Name and Address of the Physician Who Ordered the Test or Procedure	Name and Address of Facility Where Test or Procedure Was Performed	Approximate Date of Test/ Procedure

VI. OTHER MEDICAL BACKGROUND AND INFORMATION

A. To the best of your knowledge, did you use or take any of the following medications or substances BEFORE the injury that you allege you suffered occurred? **If "yes,"** please provide the first and last date on which you took the medication or substance.

	Yes	No	Date First Taken	Date Last Taken
Corticosteroids or other steroids				
Radiation therapy				
a. Head and/or Neck				
b. Other Body Part				
Chemotherapy				
Hormonal therapy (including, but not limited to, estrogen therapy, oral contraceptive, estrogen/progestin therapy, anti-estrogens, aromatase inhibitors, and anti-androgens/androgen deprivation therapy)				
Blood pressure (hypertension) medication				
Cholesterol-lowering medication				
Medication for the treatment of Rheumatoid Arthritis				
Medication for the treatment of Diabetes				
Selective Estrogen Receptor Modulators (SERMs), such as tamoxifen, Evista (raloxifene), Fareston (toremifene)				

B. Were you taking any other prescription medicines in the five (5) years prior to developing the injury you are claiming in this action?
Yes ____ No ____

If "yes," please list the medications, the first and last dates of ingestion, and reasons for taking each._____
_____
_____
_____
_____
_____

C. Have you participated in any clinical trials or taken any experimental drugs?
Yes _____ No _____

If "yes," please indicate when you participated in such trials, where the trials took place, which drugs you took, and for what condition you took such drugs. _____

D. Smoking/Tobacco Use History:

Do you now or have you ever smoked or used tobacco products?
Yes _____ No _____
If "yes," indicate with an "X" the answer and fill in the blanks applicable to your history of smoking and/or tobacco use

1. Current smoker of cigarettes ____; cigars ____; pipe tobacco ____; or user of chewing tobacco/snuff ____.

a. Amount smoked or used: on average _____ per day for _____ years.

2. Past smoker of cigarettes____; cigars ____; pipe tobacco ____; or used chewing tobacco/snuff ____.

a. Date on which smoking/tobacco use ceased: _____

b. Amount smoked or used: on average ____ per day for ____ years.

E. Alcoholic Beverage Consumption History

Do you now drink or have you in the past drunk alcohol (beer, wine, whiskey, etc.)? Yes ____ No ____
If "yes," fill in the appropriate blank with the number of drinks that represents your average alcohol consumption during the period you were taking Fosamax up to the time that you sustained the injuries alleged in the complaint:

_____drinks per week,
_____ drinks per month,
_____ drinks per year, ***or***

Other (describe): _____

F. Have you ever experienced or been diagnosed or treated for any of the following:

	Yes	No	Unknown
1. Necrosis, avascular necrosis, aseptic necrosis or osteonecrosis in any part of the body			
2. Osteoporosis			
3. Paget's disease			
4. Pancytopenia or abnormal blood count secondary to cancer and/or cancer treatment			
5. Sickle cell disease			
6. Gaucher's disease			
7. Vascular diseases, problems, or insufficiencies			
8. Autoimmune or connective tissue disorders			
a. Systemic lupus erythematosus			
b. Rheumatoid arthritis			
c. Vasculitis			
d. Crohn's disease			
e. Reynaud's syndrome			
f. Sjogren's syndrome			
g. IBD (Inflammatory Bowel Disease)			
h. Pernicious Anemia			
i. Primary Biliary Cirrhosis			
j. Other (describe): _____			
9. Acquired Immune Deficiency Syndrome (AIDS) or HIV			
10. Renal transplant, disease and/or impairment			
11. Caisson's disease,barotraumas and/or decompression sickness			

	Yes	No	Unknown
12. Pancreatitis			
13. Diabetes Mellitus			
14. Fungal infections (including, but not limited to, Aspergillis fungus)			
15. Asthma			
16. Blood disorders, dyscrasias or other blood abnormalities			
17. Dislocation of any bones in the jaw			
18. Bone disorders and/or fractures			
19. Herpes Zoster			
20. Any other liver or kidney disease(s) not mentioned above. Please specify: _____			
21. Hypothyroidism or hypoparathyroidism			

G. If you responded "**yes**" to any of the above, please provide the following information for each condition:

Condition	Name and Address of Person(s) Who Diagnosed or Treated Condition	Approximate Onset Date of Condition

H. If you are claiming a psychological or emotional injury in this case, state whether you have ever experienced or have ever been treated for any psychological, psychiatric or emotional problem (including depression) not related to your use of Fosamax.

Yes _____ No _____

If "yes," please provide the following information for each condition:

1. Describe the symptoms experienced. _____

2. Please provide the name, address, telephone number and specialty of the person who provided the diagnosis and/or treatment. _____

3. Please provide the name and address of the facility or hospital, if any, where the treatment was provided. _____

4. For each provider of care identified in subparagraphs 2 and 3, please produce an executed copy of the release form attached as Ex. C, authorizing Merck to obtain your psychotherapy notes and related

records generated by any such mental health care practitioner.

I. Have you ever suffered any injury to your head, neck, mouth or jaw?
Yes _____ No _____

If "yes," please state:

1. When the injury occurred. _____
2. The nature of the injury, including what part of the body was injured.
_____
3. Please provide the name, address, telephone number and specialty of the person who provided the diagnosis and/or treatment._____
_____
_____
4. Please provide the name and address of the facility or hospital, if any, where the treatment was provided. _____
_____
_____
5. Please identify the medications taken to treat the injury. _____
_____
_____

VII. CANCER BACKGROUND

A. Have you ever been diagnosed with cancer or metastatic disease?
Yes _____ No _____

If "yes":

1. When were you first diagnosed with cancer or metastatic disease?
_____
2. What type of cancer or metastatic disease was it? _____
_____
3. Who diagnosed this cancer or metastatic disease? (Please provide the name, address, telephone number and specialty of each diagnosing physician). _____
_____
_____
4. Have you been diagnosed with cancer or metastatic disease more than once? Yes _____ No _____

If "yes," provide the information requested in questions 1, 2, and 3 for each cancer or metastatic disease diagnosed. _____
_____
_____
_____

VIII. FOSAMAX AND OTHER BISPHOSPHONATE USE

A. Identify which of the following medications you have taken:

	Yes	No
1. FOSAMAX®		
2. FOSAMAX PLUS D®		
2. Zometa®		

	Yes	No
3. Aredia®		
4. Reclast®		
5. Actonel®:		
6. Boniva® or Bondronat®		
7. Didronel®		
8. Skelid®		
9. Nerixia®		
10. Bonefos® or Clastoban® or Clasteon® or Ostac®		
11. Osteolite®		

B. Complete the following information for each drug identified above:

Dates of Use of Drug (month/ day/year)	Dosage and Form of Dose (IV, oral)	Full Name of Physician(s) Who Prescribed	Full Address of Prescribing Physician(s)	Condition(s) Treated	Name of Facility and Street Address of Location Where Drug Was Infused, Injected or Taken or Name and Address of Pharmacy(s) Where Prescription was Filled

C. For what disease or condition were you prescribed each of the medications identified in section VIII(A):

1. Injury, illness, or disability: _____

2. Date(s) of onset: _____

3. Date(s) of diagnosis: _____

4. Please provide the name, address, telephone number and specialty of the person by whom the injury, illness or disability was first diagnosed.

5. List the treatment (surgery, medications taken or prescribed) for the injury, illness or disability. _____

D. Did you receive any samples of Fosamax? Yes ____ No _____

If "yes," provide the following:

1. Identify the full name and address of each person who provided them: _____

2. Identify the approximate date(s) when the samples were provided: ___

E. At the time you first began taking Fosamax or other bisphosphonates did you suffer from any other physical injuries, illnesses or disabilities other than the disease or condition identified in VIII(C) above? Yes _____ No _____

If "yes," identify the injury, illness, or disability, symptoms, date(s) of onset and dates(s) of diagnosis

1. Injury, illness, or disability: _____

2. Symptom(s): _____

3. Date(s) of onset: _____

4. Date(s) of diagnosis: _____

5. Please provide the name, address, telephone number and specialty of the person by whom the injury, illness or disability was first diagnosed. _____

F. To the best of your knowledge, state whether you underwent any of the following tests, procedures, or surgeries BEFORE the injury you allege you suffered occurred.

		Yes	No	Unknown
1.	Skeletal bone scan (scintigraphy), Dual Energy X-Ray Absorptiometry (DEXA) scan, or nuclear medicine imaging			
2.	MRI (including functional MRI, or MRI spectroscopy), CT or CTA scans for bone			
3.	Doppler scans			
4.	Ultrasound for bone			
5.	PET scans for bone			

		Yes	No	Unknown
6.	Interventional radiology procedure images, such as organ procedures or vascular interventional radiology procedures			
7.	Vascular surgery			
8.	Any other surgery on bone (Please describe: _____)			

G. For each test, procedure, or surgery for which you answered "**yes**," please identify the treating physician and approximate date of the test.

Test/Procedure	Name and Address of Facility Where Test/Procedure Performed	Approximate Dates of Test/Procedure

H. Did you see any written, televised or internet-based advertising or labeling materials regarding Fosamax prior to or during the time you took Fosamax? Yes _____No _____

If "yes," state which written, televised or internet-based advertising or labeling materials you recall seeing regarding Fosamax and when you saw such advertising or labeling materials, excluding any such materials that are covered by the Attorney-Client or Work Product Privileges._____

_____

_____

I. Have you ever visited any website (including any chat rooms) regarding Fosamax or any other bisphosphonates? Yes _____ No _____

If "yes," identify all websites and chat rooms visited that you recall and the approximate dates of visit, excluding any such visits that are covered by the Attorney-Client or Work Product Privileges.

_____

_____

_____

J. Instructions or Information:

1. Did you receive any written or oral instructions or information about Fosamax before you took it? Yes ____ No ____ Don't Recall _____

2. **If "yes,"** please answer the following:

a. When did you receive the instructions or information?_____
_____

b. From whom did you receive it?_____

c. What written instructions or information did you receive? _____
_____

d. What oral instructions or information did you receive? _____
_____

IX. MONETARY LOSS CLAIMS

A. Have you paid or incurred any medical expenses that are related to any condition that you claim or believe was caused by your use of Fosamax 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: _____
_____
_____
_____

B. Has your insurer, or any other entity or person, paid or incurred any medical expenses that are related to any condition that you claim or believe was caused by your use of Fosamax 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:
_____
_____
_____

Please provide an itemized statement of the nature and amount of all damages you are claiming._____
_____
_____

X. WITNESSES

Please identify all persons (not identified elsewhere in this questionnaire) who you believe possess information concerning your injury, your current medical condition, the medical condition for which you took Fosamax, and/or your claims in this case and for each, state their name, address, telephone number and a description of the information you believe they possess._____

XI. DOCUMENTS AND THINGS

Please indicate whether you or your attorney are in possession of the following documents by checking "Yes" or "No" where indicated and attach copies of the following documents to your response to this profile form. If you withhold a document or information otherwise discoverable by claiming that it is privileged or otherwise protected, you shall make any such claim expressly and describe the nature of the information or document not produced or disclosed in a manner that enables other parties to assess the applicability of the privilege or protection, in accordance with the requirements of Fed.R.Civ.P. 26(b)(5).

A. For each health care practitioner who has examined you, treated you, or consulted with other health care practitioners regarding your medical or dental condition within twelve (12) years of your first use of Fosamax to the present, produce an executed copy of the release form attached to this Plaintiff's Profile Form as Ex. A, authorizing Merck to obtain medical records from each health care practitioner.

B. Produce an additional TEN ORIGINAL SIGNED copies of the release form attached as Ex. A, leaving blank the name to whom the release is directed, authorizing Merck to obtain medical records from each health care practitioner who later becomes known to Merck who has examined you, treated you, or consulted with other health care practitioners regarding your medical or dental condition at any time.

C. For each hospital, clinic or any other facility at which you have been treated for any medical or dental condition within twelve (12) years of your first use of Fosamax to the present, produce an executed copy of the release form attached as Ex. A, authorizing Merck to obtain medical records from each such hospital, clinic or any other facility.

D. Produce an additional TEN ORIGINAL SIGNED copies of the release form attached as Ex. A, leaving blank the name to whom the release is directed, authorizing Merck to obtain medical records from any hospital, clinic or any other facility that later becomes known to Merck and at which you have been treated for any medical or dental condition at any time.

E. Has any health care practitioner examined you, treated you, or consulted with other health care practitioners regarding your medical, dental or mental condition at or in affiliation with a Veteran's Administration facility?
Yes_____ No_____

If your answer is YES, please produce an executed copy of the release form VA 10-5345 attached as Ex. B, authorizing Merck to obtain medical records from each health care practitioner.

F. Has any psychologist, psychiatrist or other mental health care practitioner examined or treated you for any psychological, psychiatric, or emotional injuries, illnesses and/or conditions allegedly suffered as a result of your treatment with Fosamax? Yes_____ No_____

If your answer is YES, please produce an executed copy of the release form Authorization for Release of Mental Health Records attached as Ex. C, authorizing Merck to obtain your mental health records, psychotherapy notes, and clinical information generated by any such mental health care practitioner.

G. A copy of all medical records from any health care provider identified in any of your responses to the questions above. Yes _____ No ____

H. All radiological or other imaging or recordings identified in any of your responses to the questions above. Yes ____ No _____

I. 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. Yes ____ No ____

J. Have you ever made a claim for Social Security benefits, disability insurance benefits, or workers' compensation benefits? Yes_____ No_____

If your answer is YES, please produce an executed copy of each applicable authorization (Form SSA-3288; Authorization for Release of Disability Insurance Records; and/or Authorization for Release of Workers' Compensation Records) attached as Ex. D, authorizing Merck to obtain all documents discussing, describing or memorializing your requests for Social Security, disability insurance, or workers' compensation benefits.

K. If you claim you have suffered a loss of earnings or earning capacity, produce copies of your Federal and State income tax returns and related tax forms (such as W-2s, 1099's, etc.) evidencing all income for each of the years from ten (10) years prior to your injury to the present. Yes ____ No ____

L. Do you claim you have suffered a loss of earnings or earning capacity? Yes_____ No_____

If your answer is YES: please produce executed copies of each of the authorizations (Form 4506 and Authorization for Release of Department of Revenue Records) attached as Ex. E, authorizing Merck to obtain your Federal and State income tax returns for each of the years from ten (10) years prior to your injury to the present.

M. If your answer to Question L is YES, please also produce an executed copy of the authorization Form SSA 7050-F4 attached as Ex. F, authorizing Merck to obtain your earnings information from the Social Security Administration.

N. If you claim you have suffered a loss of earnings or earning capacity, all documents relating to your employment at any time, including documents relating to attendance, leave of absences (whether for vacation, sick leave or other reasons), reported injuries, promotions and demotions, performance evaluations, reports of health examinations, job applications, and wages paid and/or earnings given (including W-2 forms), and all other pertinent documents, including any and all medical, psychological, or testing records or memoranda. Yes ____ No ____

O. If your answer to Question L above is YES, for each of your employers

identified in any of your responses to the questions above, please produce two executed copies of the release form Authorization for Release of Employment Records attached as Ex. G, permitting Merck to obtain your employment records, including W-2 forms.

P. Have you ever served in the military? Yes____ No _____

If your answer is YES, please produce an executed copy of Standard Form 180 attached as Ex. H, permitting Merck to obtain your military personnel, service, and health records.

Q. Copies of all documents from any healthcare provider (as defined above) or others discussing, describing, relating to, or memorializing your treatment with Fosamax or to any condition you claim is related to the use of Fosamax. Yes ____ No ____

R. For each insurance company or other organization that has insured you from twelve (12) years prior to your first use of Fosamax to the present, produce an executed copy of the authorization, attached as Ex. I, authorizing Merck to obtain all insurance records from each such company.

S. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, handouts or other materials distributed with or provided to you in connection with your use of Fosamax. Yes ____ No ____

T. Copies of advertisements, written or Internet materials or promotions for Fosamax which you saw prior to or during your use of the medication. Yes ____ No____

U. Copies of all websites you visited regarding Fosamax or any other bisphosphonates, your injuries and/or this lawsuit, not including those items covered by the Attorney-Client or Work Product Privileges. Yes ____ No ____

V. Copies of transcripts of Internet chat room discussions in which you participated regarding Fosamax, any other bisphosphonates, your injuries and/or this lawsuit, not including those items covered by the Attorney-Client or Work Product Privileges. Yes ____ No ____

W. Copies of email relating to Fosamax, any other bisphosphonates, your injuries and/or this lawsuit, not including those items covered by the Attorney-Client or Work Product Privileges. Yes ____ No ____

X. All documents relating to Fosamax or any alleged health risks or hazards related to these drugs in your possession at or before the time of the injury alleged in your Complaint. Yes ____ No ____

Y. All documents you (and not your lawyer) obtained directly or indirectly from Merck. Yes ____ No ____

Z. All diaries, calendars or any other writings or recordings made by you, or by any other person, describing, discussing, explaining or referring to the injuries, damages, or causes of action alleged by you in the Complaint, not

including those items covered by the Attorney-Client or Work Product Privileges. Yes ____ No ____

AA. All diaries, calendars or any other writings or recordings made by you, or by any other person, describing, discussing, explaining or referring to the underlying illness or disease for which you received Fosamax, not including those items covered by the Attorney-Client or Work Product Privileges.
Yes ____ No ____

BB. Copies of all documents you (and not your attorneys) obtained from any source related to Fosamax or to the alleged effects of such medications, not including those items covered by the Attorney-Client or work Product Privileges.
Yes ____ No ____

CC. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider.
Yes ____ No ____

DD. Decedent's death certificate (if applicable).
Yes ____ No ____ Not applicable ____

XII. LIST OF MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

Identify the following:

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

Name	**Address**	**Specialty**	**Approximate Dates of Treatment**

B. Identify each of your *other* primary care physicians for the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

Name	**Address**	**Specialty**	**Approximate Dates of Treatment**

C. Each hospital, clinic, or healthcare facility where you have received inpatient treatment or been admitted as a patient during the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

Name	**Address**	**Admission Dates**	**Reason for Admission**

D. Each hospital, clinic, or healthcare facility where you have received outpatient treatment (including treatment in an emergency room) during the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

Name	Address	Treatment Dates	Reason for Treatment

E. Identify each health care provider who has ever seen or treated you for osteoporosis or the underlying illness for which you took Fosamax.

Name	Address	Specialty	Approximate Dates of Treatment

F. Each dentist, orthodontist, periodontist, oral and maxillofacial surgeons or other healthcare provider involved in providing dental care or treatment who you have ever seen or from whom you have ever received treatment.

Name	Address	Specialty	Approximate Dates of Treatment

G. Identify any other healthcare provider by whom you have been seen or from whom you have received treatment for any reason during the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

Name	Address	Specialty	Approximate Dates of Treatment

H. If you are claiming any psychological or emotional damages, identify each psychiatrist, psychologist, mental health counselor, therapist and/or social worker from whom you have received treatment or with whom you have consulted regarding your health during the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

Name	Address	Specialty	Approximate Dates of Treatment

I. Each pharmacy that has dispensed medication to you in the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

Name	Address

DECLARATION

I declare under penalty of perjury that all of the information provided in this Plaintiff Profile Form is true and correct to the best of my knowledge, I have supplied all the documents requested in part XI of this Profile Form to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and I have supplied the authorizations attached to this declaration.

Signature	Print Name	Date