IN RE: LEVAQUIN LITIGATION	SUPERIOR COURT OF NEW JERSEY LAW DIVISION:ATLANTIC COUNTY CASE NO. 286 CIVIL ACTION PLAINTIFF FACT SHEET

PLAINTIFF FACT SHEET

Please provide the following information for each individual on whose behalf a claim is being made. If you are completing this Plaintiff Fact Sheet in a representative capacity, please respond to the remaining questions with respect to the person who was exposed to Levaquin®. Whether you are completing this fact sheet for yourself or for someone else, please assume that "You" means the person who was exposed to Levaquin®. In filling out this form please use the following definition: "healthcare provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, and any pharmacy, x-ray department, radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, chiropractor, or other persons or entities involved in the diagnosis, care and/or treatment of you.

In filling out any section or sub-section of this form, please submit additional sheets as necessary to provide complete information. In addition, if you learn that any of your responses are incomplete or incorrect at any time, please supplement your responses to provide that information as soon as you become aware of this information. This form requests information and documents about your medical condition for the past ten (10) years. However, defendants reserve the right to request additional information and information for a time period dating further back than ten (10) years on a case by case basis, at which time the parties will meet and confer as the issue arises. Further, defendants expressly reserve the right to request information and documents concerning all Levaquin exposure.

1. Name of person completing this form: _____

2. Name of person on whose behalf a claim is being made:_____

3. Please state the following for the civil action that you filed:

a. Case caption:

b. Docket Number: _____

c. Name, address, telephone number, fax number and e-mail address of principal attorney representing you:

Name: _____

Firm: _____

Address: _____

Telephone Number: _____

Fax Number: _____

E-mail Address: _____

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

a. Your name, including other names you have used or by which you have been known and dates you used those names:

_____

b. Current Address: _____

c. In what capacity are you representing the individual or estate: _____

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

Court which appointed you: _____

e. What is your relationship to the individual you represent: _____

_____

f. If you represent a decedent's estate, state:

Date of Death: _____

THE REST OF THIS FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO WAS EXPOSED TO LEVAQUIN®

I. PRODUCT IDENTIFICATION

1. Have you ever taken Levaquin®?

   Yes _____ No _____

2. If yes, please provide the following information. Use additional pages to continue your answer if necessary:

   a. Date(s) of prescription(s):_____

   b. For how many days did you take each prescription?: _____

   c. Dosage (including how many times per day): _____

   d. Name of the healthcare provider(s) who prescribed Levaquin®:

   _____

   e. Name and address of the pharmacy/pharmacies where Levaquin® was obtained:

   _____

   f. Reason for prescription: _____

3. Were you given any **written** instructions, warnings or other information about Levaquin®?

   Yes _____ No _____ Do not recall _____

   If Yes, describe the materials you received, identify who provided them, and state whether you or your attorneys still have the materials. (If you have the materials, please produce a copy.):

   _____

4. Were you given any **verbal** instructions, warnings or other information about Levaquin®?

   Yes _____ No _____ Do not recall _____

   If Yes, describe the information you received, when you received it and identify who provided it:_____

II. PERSONAL INFORMATION

1. Name: _____

2. Maiden or other names used and dates you used those names:

_____

3. Current address and date when you began living at this address:

_____

4. Identify each address at which you resided during the last ten (10) years, and the dates you resided at each one.

Address	Dates of Residence

5. Social Security Number: _____

6. Date and place of birth: _____

7. Current marital status: _____

8. Spouse's name and date of marriage: _____

9. If married, has your spouse filed a loss of consortium or other claim in this action?

Yes _____ No _____

10. If your spouse is asserting a loss of consortium claim, state his or her occupation:

_____

11. If you have children, list their names and ages

_____

_____

12. Identify all schools you attended, starting with high school:

Name of School	Address	Dates of Attendance	Degree Awarded	Major or Primary Field

13. Are you currently employed? Yes _____ No _____

If yes, please identify your current employer with name, address and telephone number and your position there: _____

_____

If not, did you leave your last job for a medical reason? Yes _____ No _____

If Yes, describe why you left:

_____

14. Please identify all of your employers for the last 10 years, with name, address, and telephone number, your employment dates, your position there, and your reason for leaving:

Name of Employer	Address and Telephone Number	Dates of Employment	Your Position	Reason for Leaving

15. Have you ever served in any branch of the military? Yes _____ No _____

Branch and dates of service: _____

If yes, were you ever discharged for any reason relating to your medical, physical or psychiatric condition? _____

16. Identify each insurance carrier with whom you had health insurance coverage at any time in the past 10 years, and please include all private insurance and public assistance if applicable:

Name of Company	Policy Number	Name of Policy Holder/Insured (if different than you)	Approximate Dates of Coverage

17. Have you applied for workers' compensation, social security, and/or state or federal disability benefits within the past ten (10) years?

Yes _____ No _____

If yes, then as to each application, separately state:

a. Date (or year) of application: _____

b. Nature of claimed injury/disability: _____

c. To what agency or company did you submit your application: _____

_____

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

Yes _____ No _____

Party You Sued/Made Claim Against	Court in Which Suit Was Filed/Claim Was Made	Case/Claim Number	Attorney Who Represented You	Nature of Claim and Injury

19. Have you been convicted of, or pled guilty to, a felony and/or a crime of fraud or dishonesty within the past ten years?

Yes _____ No _____

If Yes, please state the charge to which you plead guilty or which you were convicted of, as well as the court where the action was pending:

_____

III. HEALTHCARE PROVIDERS

1. Identify each doctor or healthcare provider who you have seen for medical care and treatment in the past 10 years:

Name and Specialty	Address and Telephone Number	Approx Dates/Years of Visits

2. Identify each hospital, clinic, or healthcare facility where you were hospitalized (in-patient, out-patient, or emergency room visit) in the past 10 years inclusive of all surgeries and transplants.

Name	Address and Telephone Number	Admission Date(s)	Reason for Admission

3. Identify each pharmacy that has dispensed medication to you in the past ten (10) years:

Name of Pharmacy	Address and Telephone Number of Pharmacy	Approx Dates/Years You Used Pharmacy

IV. MEDICAL BACKGROUND

1. Smoking History

a. Have you ever smoked cigarettes? Yes _____ No _____

State amount smoked: _____ packs per day for _____ years, during the years _____ to _____.

b. Have you ever smoked cigars or pipe tobacco or used smokeless tobacco?

Yes _____ No _____

State amount smoked/utilized: _____ cigars/pipes/smokeless tobacco per day for _____ years, during the years _____ to _____.

2. Allergies and Allergic Reactions

a. Have you ever experienced an allergic reaction to any food, medication or pharmaceutical (including contract agents)?

Yes _____ No _____ If Yes, please state the following:

Food, Medication or Pharmaceutical	When Allergy Diagnosed	Symptoms of Allergy	Health Care Provider Who Diagnosed Allergy

3. Other Conditions

a. To the best of your knowledge, have you ever experienced or been diagnosed with any of the following conditions during the ten years before your alleged event? Please select Yes or No for each condition. For each condition for which you answer Yes, please provide the additional information requested in the table following this chart:

Condition Experienced or Diagnosed	Yes	No
1. Any tendon condition or injury, including tendonitis, tenosynovitis, tendinopathy, and tendon rupture.		
2. Any disorder or abnormality of blood vessels or		

Condition Experienced or Diagnosed	Yes	No
circulatory system (e.g. aneurysm, arteriovenous)		
3. Any cardiac condition (e.g. arrhythmia or dysrhythmia, heart attack, angina, congestive heart failure, cardiomyopathy, enlarged heart, coronary artery disease, blocked or narrowed arteries, heart valve conditions)		
4. Skin conditions, including infection, abscess, cellulitis, impetigo, wound infections, skin ulcers, eczema and/or psoriasis		
5. Arthritis (e.g., osteoarthritis or rheumatoid arthritis)		
6. Autoimmune disease or condition or connective tissue disease or disorder (e.g. lupus, mixed connective tissue disorder, B2-microglobulin amyloidosis, Lipodermatosclerosis/chronic venous statis, Morphea/lichen sclerosis et atrophicus, Raynaud's Syndrome, rheumatologic condition, Scleredema diabeticorum, scleroderma, scleromyxedema, Sjogren's Syndrome)		
7. Bleeding or clotting disorders or predispositions		
8. Brain or neurological disorder (e.g. tumors, stroke, cerebrovascular disease)		
9. Cancer (including blood cancers such as leukemia)		
10. Chronic inflammatory conditions, such as inflammatory bowel disease, Crohn's disease or other pro-inflammatory disease		
11. Diabetes		
12. Endocrine condition or disease (e.g. malfunction of the pancreas, parathyroid, thyroid, adrenal or pituitary, hyperparathyroidism, etc)		
13. Fibromyalgia		
14. Gastrointestinal problems (e.g., ulcers, heartburn, acid reflux, GERD, gallbladder disease, colitis, intestinal obstruction)		
15. Hepatorenal syndrome		
16. High blood pressure or low blood pressure		
17. High cholesterol or triglycerides; hyperlipdemia or lipid metabolism disorders		
18. Infectious disease (e.g., tuberculosis, pneumonia, rheumatic fever, typhoid fever, encephalitis, poliomyelitis, malaria)		

Condition Experienced or Diagnosed	Yes	No
19. Immunosuppression disorders (e.g. HIV/AIDS)		
20. Kidney disease or condition (e.g., renal insufficiency, acute or chronic renal failure, end-stage renal disease, cysts, pruritus of renal disease/neuropathy)		
21. Kidney transplant or any other transplant surgery or attempted surgery		
22. Liver disorder or disease (e.g. cirrhosis, hepatitis)		
23. Lung disease (e.g., chronic obstructive pulmonary disease, chronic lung disease, emphysema, asthma, pulmonary hypertension or other lung disease)		
24. Neurological disease or condition (e.g., multiple sclerosis, ALS, Parkinson's disease, Alzheimer's)		
25. Neurological disorders (e.g., paralysis or any condition affecting movement or mobility)		
26. Sexually transmitted disease or infections (e.g.: syphilis, gonorrhea, Chlamydia, herpes)		
27. Sleep Apnea		
28. Thrombotic events (e.g., heart attack, transient ischemic attack, stroke deep vein thrombosis, portal vein thrombosis or pulmonary embolism)		
29. Vascular disease (e.g. peripheral vascular disease, peripheral arterial disease, vasculitis, phlebitis)		

b. For each condition for which you answered Yes in the previous chart, please provide the information requested below:

Condition You Experienced	Approximate Date of Onset	Name, Address and Telephone Number of Treating Physician (if any)

4. Surgeries/Procedures

For each surgery (invasive or non-invasive), procedure or therapy (including radiation therapy, hyperbaric oxygen therapy, immunotherapy, etc.) that you have undergone in the past ten years, please provide the information requested below:

Date	Procedure	Facility	Physician Ordering	Physician Administering	Purpose

V. MEDICATIONS

1. List all of the medications you currently take.

Medication	Dose/ Frequency	Physician Ordering	Pharmacy Dispensing	Purpose

2. To the best of your recollection, do you currently take or have you ever taken in the past ten years, any of the following medications, pharmaceutical products, supplements, or herbal remedies:

Name of Medication	Yes	No	Do Not Recall	If Yes, date(s) taken and prescribing doctor	Name and address of pharmacy where obtained
Ciprofloxacin, norfloxacin, ofloxacin, enoxacin, lomefloxacin, or other fluoroquinolones					
Herbal remedies					
Vitamins					
Amphetamines					
Antibiotics, besides					

Name of Medication	Yes	No	Do Not Recall	If Yes, date(s) taken and prescribing doctor	Name and address of pharmacy where obtained
fluoroquinolones					
Anti-depressants					
Anti-inflammatories					
Anxiety medications					
Anti-rejection medications					
Blood pressure medications					
Blood thinners					
Chemotherapy					
Cholesterol medications					
Diabetic medications					
Diet medications					
Heart medications					
Hormone therapy					
Pain medications					
Steroids, whether oral or injected, including but not limited to dexamethasone, prednisone, prednisolone and methylprednisolone					
CHOLESTEROL-LOWERING DRUGS					
Lescol [Fluvasatin]					
Lipitor [Atorvastatin]					
Mevacor [Lovastatin]					
Pravachol [Pravastatin]					
Zocor [Simvastatin]					
Niacin [Vitamin B3]					
LoCholest [Cholestyramine]					
Questran [Cholestyramine]					
Prevalite [Cholestryramine]					
TRIGLYCERIDE-LOWERING DRUGS					
Lopid [Gemfibrozil]					
Tricor [Femofibrate]					
Bezafibrate					
Ciprofibrate					
ANTI-INFECTIVE DRUGS					
Difulcan [Fluconazole]					

Name of Medication	Yes	No	Do Not Recall	If Yes, date(s) taken and prescribing doctor	Name and address of pharmacy where obtained
Erythrocin & Others [Erythromycin]					
Flagyl [Metronidazole]					
Nizoral [Ketoconazole]					
Sporanox [Itraconazole]					
IMMUNOSUPPRESSIVE DRUGS					
Neoral [Cyclosporine]					
Sandimmune [Cycloporine]					
OTHER					
Anticoagulants					
Heart Drugs					
Thyroid Medications					
Other					

3. If you indicate Yes, to any of the above medications/drugs please provide the following information:

Name of Medication/Drug Used	Dates of Use (Approx.)	Who prescribed medication (i.e. doctor's name or clinic/hospital name)	Purpose

4. To the best of your recollection, are there any prescription medications other than those identified that you have taken on a regular basis in the last ten (10) years for any duration more than two months?

Yes _____ No _____

If Yes, please identify the medication(s), the doctor(s) who prescribed it, the approximate dates/years you have taken this medication, and why it was given to you:

Name of Medication	Who prescribed medication (i.e., doctor, clinic or hospital name)	Date of Use	Purpose

VI. FAMILY MEDICAL HISTORY

Please indicate, to the best of your knowledge, whether your parents, siblings, children or grandparents have ever experienced or been diagnosed with any of the conditions listed above in Section IV. For any such conditions, please indicate which one(s) and provide the following information:

Condition	Date of Onset (Approx)	Relationship to You	Treatment

VII. INJURIES & DAMAGES

1. Are you claiming any injury as a result of exposure to Levaquin®?

Yes _____ No _____

If Yes, please describe in detail your physical injury(ies) you claim were caused as result of your exposure to Levaquin®:

_____

_____

_____

_____

_____

_____

_____

2. Are you claiming that exposure to Levaquin® caused you to have any tendon condition or injury, including tendonitis, tenosynovitis, tendinopathy, or tendon rupture?

Yes _____ No _____ If Yes, please answer the following:

a. Have you been diagnosed with any of these conditions? Yes ____ No ____

b. What healthcare provider diagnosed you with any of these conditions and when?

_____

_____

_____

_____

_____

_____

c. What treatment have you undergone or are you undergoing?

_____

_____

_____

d. What treatment options were considered?

_____

_____

3. Have you ever been hospitalized as a result of any of these conditions? _____

Yes _____ No _____

If Yes, please provide the following information:

a. Approximate date(s) of hospital admission _____

b. Approximate date(s) of discharge: _____

c. Hospital names(s) and address(es): _____

_____

4. Do you claim in this lawsuit that your exposure to Levaquin® caused or aggravated any psychiatric and/or psychological condition(s)

Yes _____ No _____

If Yes, please state the following as it pertains to your treatment for any psychiatric and/or psychological condition(s) since the age of 18 (or, if under 18, since birth):

Condition	Name and Address of Mental Healthcare Provider (if any)	Approx. Dates/Years of Treatment/Visits (if any)

5. Are you making a claim for lost wages or lost earning capacity?

Yes _____ No _____

If Yes, describe your claim and attach your W-2 forms or other tax documents for the past (5) years:

_____

_____

_____

VIII. DECEASED INDIVIDUALS AND AUTOPSY INFORMATION

1. Are you filling this out on behalf of an individual who is deceased?

Yes _____ No _____

If Yes, please state the following from the Death Certificate of the individual:

(NOTE: In lieu of the following, please attach a copy of the death certificate)

Date of death: _____

Place of death (city, state and country): _____

_____

Facility or location where death occurred: _____

_____

Name of physician who signed death certificate: _____

_____

Cause of death: _____

_____

2. Are you filling this out on behalf of an individual who is deceased and on whom an autopsy was performed?

Yes _____ No _____ If Yes, please fill in the information below pertaining to the autopsy and the autopsy report:

(NOTE: In lieu of the following, please attach a copy of the autopsy report.)

Date of death: _____

Place of death (city, state and country): _____

_____

Facility or location where death occurred: _____

_____

Name of physician who signed death certificate: _____

_____

Cause of death: _____

IX. DOCUMENT DEMANDS

These requests are seeking documents in your possession, including the signing of the authorizations that are provided with this Plaintiff Fact Sheet, writings on paper or in electronic form. Thus if you have any of the following materials in your custody or possession, please attach a copy to this Fact Sheet. These document requests are not intended to seek attorney client communications, attorney work product materials. In addition these requests do not encompass or seek information about expert witnesses or communications with and/or form experts or proposed trial exhibits or trial materials which may be subject to disclosure at a later date in accordance with subsequent Court Order or rule. Thus if you have any of the following in your possession and is not protected as set forth above please provide a copy of it with this Plaintiff Fact Sheet.

1. Authorizations:

2. Documents in your possession, includes writings on paper or in electronic form. If you have any of the following materials in your custody or possession, please attach a copy to this Fact Sheet.

    a. Any and all of your medical records, medical billing records or insurance records in your possession, custody or control.

    b. Copies of the entire packaging, including the bottle, box, label, and package insert, for Levaquin® as well as any remaining medication, and any pharmacy packaging and receipts for any other prescription medication you took while taking Levaquin®.

    c. Copies of the entire packaging, including the bottle, box, label, and package insert, as well as any remaining medication, and any pharmacy packaging and receipt for any other prescription medication you took while taking Levaquin®.

    d. A copy of all medical records and/or documents relating to the exposure to Levaquin® at any time in your life.

    e. Any and all records which reflect or are related to a diagnosis of any tendon condition or injury, including tendonitis, tenosynovitis, tendopathy, and tendon rupture or any allegedly related conditions.

    f. All documents in your possession, custody or control, concerning or relating to Levaquin® and/or all defendants in this lawsuit.

    g. All documents in your possession, custody or control, concerning or relating to tendonitis, tenosynovitis, tendinopathy, and tendon rupture or any allegedly related conditions.

h. All documents in your possession, custody or control which where provided to you by any of the parties you have sued, or any pharmacy that distributed Levaquin®.

i. All documents constituting any communications or correspondence between you and any representative of the parties you have sued, or any pharmacy that distributed Levaquin® to you.

j. All photographs, drawings, diaries, journals, calendars, notes, slides, videos, DVDs or any other media relating to your alleged injury(ies) or your life after your alleged injuries began.

k. If you claim you have suffered a loss of earnings or earnings capacity, your federal tax returns for each of the last five (5) years or W-2s or other tax documents, such as 1099s, for each of the last five (5) years.

l. Documents relating to any claim for damages, including, but not limited to, medical, hospital, pharmacy or other bills.

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

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

X. VERIFICATION

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

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in some material respects incomplete or incorrect.

Date: _____ _____

Signature