SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

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IN RE: NEW YORK DIET DRUG LITIGATION Index No. 700000/98

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THIS DOCUMENT APPLIES TO ALL DIET DRUG CASES VENUED IN NEW YORK COUNTY

CASE MANAGEMENT ORDER NO. 2
July 9, 1998

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I. Standard Consolidated Disclosure of Plaintiffs

A. Promulgation of Uniform Requests

1. Pursuant to Case Management Order No. 1 entered in these coordinated cases on May 28, 1998, this Court, inter alia, established steering committees, and joint subcommittees, of plaintiffs' and defendants' counsel to develop uniform pleadings and discovery requests to be used in these cases. To date, these committees have jointly developed the a Uniform Demand for Verified Bill of Particulars in Individual Cases, which is annexed hereto as Exhibit A (the "Demand"), and a uniform set of interrogatories, document requests and request for authorizations entitled Plaintiff's Initial Discovery, which is attached hereto as Exhibit B (the "PID").

2. The Demand and the PID, filed as a part of this Order under the index number 700000/98, are applicable to each and every case that is or becomes subject to this Order.

B. Responding to the Uniform Requests

1. Plaintiffs shall serve their responses to the Demand and the PID within the time provided for in this Order upon all defendants in the individual actions to which the responses pertain, providing the particulars demanded, the information, documents and authorizations requested, and the verification and sworn declaration as indicated. The originals, including the authorizations, shall be sent to Defendants' Liaison Counsel, who shall be responsible for distributing the original authorizations to the appropriate defense counsel. In cases involving a health care provider, an additional set of original authorizations shall be sent to counsel for such health care providers.

2. Plaintiffs' responses to the Demand and to the PID shall be served in accordance with the following schedule:

a. For each of the diet drug cases that is presently before this Court, plaintiffs' responses shall be served within ninety (90) days of the date of this Order;

b. With respect to cases commenced in this Court after the date of this Order, plaintiffs' responses shall be served within ninety (90) days from the commencement of the action;

c. With respect to cases transferred to this Court from other courts within the State after the date of this order, plaintiffs' responses shall be served within ninety (90) days from the transfer date.

3. After receipt of the responses of the plaintiff in any individual case, any defendant may seek additional written discovery from the plaintiff upon leave of Court for good cause shown and only to the extent that such additional discovery is material, necessary and not repetitive of the Demand and the PID and cannot be obtained through deposition. Defense counsel are admonished to exercise good faith in determining the necessity for such additional written discovery.

II. Further Contemplated Actions

1. As provided for in Case Management Order No. 1, the steering committees are charged with negotiating with respect to master pleadings to be used in these cases as well as forms of standard consolidated discovery of the defendants (specifically, documents request and interrogatories). The pleadings subcommittees shall prepare and submit for the Court's approval forms of a master complaint and master answer (with appropriate adoption forms) for use in these cases. The discovery subcommittees shall prepare and submit for the Court's approval standard document requests and interrogatories to the defendants. The discovery subcommittees shall thereafter submit to the Court their proposal for the scheduling of depositions and other discovery.

III. Other Matters

1. Plaintiffs' and Defendants' Liaison Counsel are hereby directed to mail a copy of this Order to all counsel who have appeared in these actions for plaintiffs and defendants, respectively.

SO ORDERED.

Dated: July 9, ~~May ___~~, 1998
New York, New York

Helen E. Freedman, J.S.C.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

IN RE: NEW YORK DIET DRUG LITIGATION	:	
THIS DOCUMENT APPLIES TO: ALL DIET DRUG CASES VENUED IN NEW YORK COUNTY	:	Index No. 700000/98

UNIFORM DEMAND FOR VERIFIED BILL OF PARTICULARS IN INDIVIDUAL CASES

PLEASE TAKE NOTICE that defendants hereby demand that each and every plaintiff serve and file with the Clerk of the Court, within the time prescribed by Case management Order No. 2, entered in these cases on May __, 1998, a verified bill of particulars setting forth the particulars of their allegations as follows:

1. Each plaintiff's full name.

As to each manufacturer, distributor or pharmacy defendant:

2. As to each defendant that you allege was negligent in any way: describe in detail each of the acts or omissions you claim constitute the negligence claimed as to each such defendant including the manner in which it is claimed that each such act or omission caused injury to the plaintiff and identification of any standards, codes, regulations, rules, laws or other legal standards that plaintiff asserts support his or her claim.

Ex. A

3. If you claim that any defendant failed properly and adequately to give warnings with respect to any diet drug at issue, for each such defendant: describe in detail what warnings or information plaintiff alleges should have been provided, including to whom the warnings or information should have been provided, how the warnings or information would have prevented plaintiff's alleged injuries and the identification of any standards, codes, regulations, rules, laws or other legal standards that plaintiff asserts support the claim that adequate warnings or information were not provided.

4. If you claim that any diet drug was defective, set forth for each such product a description of the defect, including: the precise nature of each alleged defect, when the plaintiff first became aware of the defect, when and how the plaintiff notified the defendants of the existence of the defect, how the defect caused harm to the plaintiff, any alleged alternative designs for the product proposed by the plaintiff, whether you claim that defendant knew or should have known of the defective nature of the product and, if you claim that any defendant knew of the defective nature of the product, the basis for the claim and when it is you allege that each such defendant became aware of the defect.

5. If you claim that any defendant made and breached any express warranty with respect to any diet drug at issue, provide the following information for each such defendant, each such product and each such warranty: describe in detail each express warranty, including the terms of the warranty, to whom it was conveyed, the manner in which

each warranty was conveyed, the date upon which it was conveyed and how the defendant allegedly breached each such warranty.

6. If you claim that any defendant breached an implied warranty with respect to any diet drug at issue, provide the following information for each such defendant, each such product and each such warranty: describe in detail the alleged intended use for each product, whether plaintiff used the product as specified by the manufacturer, the terms of the implied warranty, to whom the implied warranty was conveyed, the date and manner in which it was conveyed, and how the defendants allegedly breached such implied warranty.

As to each health care defendant:

7. If you claim that a health care defendant was negligent, careless or unskillful, state the manner and respect in which it is claimed that each such defendant(s), was negligent, careless and unskillful, including but not limited to the following:

a. each test or procedure which you claim should not have been performed by the defendant;
b. each test or procedure which you claim was performed improperly by the defendant and in what respect;
c. each drug or medication which you claim should not have been administered by the defendant;
d. each drug or medication which you claim was administered in an improper dosage or manner, or both, by the defendant and in what respect;
e. each additional drug which you claim should have been administered by the defendant;
f. if you claim that a misdiagnosis was made by the defendant, state what the misdiagnosis was and state what the proper diagnosis should have been;

g. if you claim that there was a lack of adequate consultation by the defendant, state each specialist who should have been consulted, and at what point in the treatment;

h. if you claim that any defendant ignored any signs, symptoms, complaints or past history, identify the signs, symptoms, complaints or past history which were ignored;

i. if you claim that the plaintiff was not an appropriate candidate to receive the medication complained of, state in detail the basis for the claim that the plaintiff was not an appropriate candidate; and

j. if you claim that the plaintiff was improperly monitored, state the basis of this claim.

8. If you claim that a health care defendant performed or undertook any part of the treatment without the patient's informed consent, set forth the following:

a. the procedure(s) and/or treatment(s) performed or undertaken without the patient's informed consent;

b. for each procedure(s) and/or treatment(s) performed or undertaken without the patient's informed consent, set forth the following:

(1) the risks of the procedure and/or treatment known to the patient before it was performed;

(2) the information concerning the risks imparted to the patient by the defendant;

(3) the information concerning the risks imparted to the patient by other physicians;

(4) any assurances provided to the defendant or others by the patient that the patient would undergo the treatment, procedure or diagnosis regardless of the risks involved, or that the patient did not want to be informed of the matters to which he would be entitled to be informed by the defendant;

(5) the circumstances making it reasonably possible for the defendant to obtain consent by or on behalf of the patient; and

(6) the additional information, if any, which the defendant should have provided the patient concerning the procedure and/or treatment.

9. If you claim that any of the acts or omissions were performed by another for whose acts or omissions the health care defendant has legal responsibility, state as to each such act or omission the name of the person who performed it, and that person's legal relationship to the defendant.

10. Set forth the following:

a. the date of each treatment claimed to have been rendered by the defendant-physician(s);

b. the date of each act of negligence claimed to have been committed by the defendant-physician(s);

c. the place of each treatment claimed to have been rendered by the defendant-physician(s); and

d. the names of any medications prescribed by the defendant-physician(s) and the dates on which each medication was prescribed.

As to all defendants:

11. If you claim you were injured as the result of the ingestion of a diet drug, set forth:

(a) the exact location, nature, extent and duration of each alleged injury;

(b) whether you ever experienced any signs or symptoms of your alleged injury before you took the diet drug(s) at issue and, if so, when such signs or symptoms were experienced, how long they lasted and whether you ever sought treatment for them;

(c) whether any of your alleged injuries resulted in any limitation of motion, loss of use or loss of function and. if so. the nature, extent and degree of permanency of said injuries: and

(d) for each injury alleged, state how each product is alleged to have caused or contributed to such injury.

12. Set forth the amount of special damages (past, present and future), setting forth the charges and listing each bill separately, which plaintiff claims for:

(a) physician's services;

(b) hospital expenses;

(c) nurses' services;

(d) drugs, medicine and medical supplies, including any appliances;

(e) household help;

(f) X-ray expenses and the cost of other medical tests;

(g) loss of earnings and the rate at which they are calculated: and

(h) any other items of special damages claimed.

13. If you claim that any defendant should be liable for punitive or exemplary damages, set forth in detail for each such defendant the basis for such allegation including without limitation each alleged fact that you assert would, if proven, support the claim for such damages.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

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IN RE: NEW YORK DIET DRUG LITIGATION :

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THIS DOCUMENT APPLIES TO:
ALL DIET DRUG CASES
VENUED IN NEW YORK COUNTY : Index No. 700,000/98

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PLAINTIFFS' INITIAL DISCOVERY

This Plaintiffs' Initial Discovery must be completed by each plaintiff who used any of the diet drugs at issue in these cases or who is the representative of a person or the estate of a deceased person who used the diet drugs and has an action filed which is governed by Case Management Order No. 2, dated May __, 1998.

Instructions to the Plaintiff

A. This questionnaire contains many detailed questions regarding your health and medical history. It is necessary for you to answer these questions in connection with your lawsuit against the defendants.

B. Unless otherwise instructed by your attorney, you should complete this entire questionnaire.

C. Your answers to the questionnaire are given under oath. You must answer each question truthfully, to the best of your ability, giving accurate and complete answers.

D. Please type or legibly print your answers to each question.

E. If you need additional space to complete any answer, indicate that your answer is continued on a separate sheet, then identify the question and continue your answer on the separate sheet in the same format as found in the body of the questionnaire.

F. When you have completed the questionnaire and assembled the documents requested herein, please return the completed questionnaire and the documents to your attorney.

Ex. B

G. Please be advised that your responses to certain of the questions will be confidential and your privacy will be respected.

I: CASE INFORMATION

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

   a. Case Caption:_____

   b. Index No.:_____

   c. Court in which action originally brought (transferor county):

   _____

   d. Original index number in the transferor court.

   Index No. _____

   e. 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

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

   a. _____
   Your Name

   b. _____
   Street Address

   c. _____
   City, State and Zip Code

d. In what capacity are you representing the individual:

_____

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

_____ _____
Court Date of Appointment

f. Your relationship to deceased or represented person:

_____

g. 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.

II: PERSONAL INFORMATION

1. Last Name: _____

   First Name: _____

   Middle Name or Initial: _____

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

   _____

3. Present Street Address: _____

   _____
   City State Zip Code

4. Current or last employer:

   _____
   Name

   _____
   Address

   _____
   Dates of Employment

   _____
   Occupation

5. Social Security Number: _____

6. Date of Birth: _____

7. Sex: Male _____ Female _____

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

Yes _____ No _____

If yes, please state:

a. What branch and the dates of service.

_____

b. Were you discharged for any reason relating to your health or physical condition?

Yes _____ No _____

If yes, state what that condition was.

_____

9. 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.

_____

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

Yes _____ No _____

If yes, please state

a. Year claim was filed: _____

b. Where claim was filed:

Name: _____

Street Address: _____

City, State, Zip Code: _____

c. Claim/docket number, if applicable: _____

d. Nature of disability: _____

e. Period of disability: _____

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

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

Yes _____ No _____

If yes, please state

a. Year claim was filed: _____

b. Where claim was filed:

Name: _____

Street Address: _____

City, State, Zip Code: _____

c. Nature of disability: _____

d. Period of disability: _____

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

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

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.

_____

_____

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

Yes _____ No _____

III: FAMILY INFORMATION

1. Are you currently married?

Yes _____ No _____

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

Yes _____ No _____

3. Spouse's name: _____

4. Spouse's date of birth: _____

5. Spouse's occupation: _____

6. Has any parent, grandparent or sibling been diagnosed with heart, lung, or liver problems?

Yes _____ No _____ I don't know _____

If yes, provide the information requested below.

a. Relation: _____

Type of problem: _____

b. Relation: _____

Type of problem: _____

c. Relation: _____

Type of problem: _____

IV: MEDICAL BACKGROUND

1. Height: _____

2. Weight before use of fenfluramine (Pondimin), dexfenfluramine (Redux) and/or phentermine:

_____

3. Current Weight: _____

4. Have you ever used any of the following?

Substance	Date First Taken	Date Last Taken
a. Oral contraceptives		
Yes ___ No ___ I don't recall ___	___/___/___	___/___/___
b. Antidepressants		
Yes ___ No ___ I don't recall ___	___/___/___	___/___/___
c. Heart medications		
Yes ___ No ___ I don't recall ___	___/___/___	___/___/___
d. Blood pressure medication		
Yes ___ No ___ I don't recall ___	___/___/___	___/___/___
e. Thyroid supplements		
Yes ___ No ___ I don't recall ___	___/___/___	___/___/___
f. Diuretics		
Yes ___ No ___ I don't recall ___	___/___/___	___/___/___
g. Amphetamines		
Yes ___ No ___ I don't recall ___	___/___/___	___/___/___
h. Any use of cocaine, crack cocaine, or heroin or use of marijuana on more than 4 occasions		
Yes ___ No ___ I don't recall ___	___/___/___	___/___/___
i. Non-prescription intravenous injections		
Yes ___ No ___ I don't recall ___	___/___/___	___/___/___
j. Inhaled non-prescription substance (e.g., inhalation of glue or toluene)		
Yes ___ No ___ I don't recall ___	___/___/___	___/___/___

Substance	Date First Taken	Date Last Taken
k. Methysergide (Sansert)		
Yes ___ No ___ I don't recall ___	___/___/___	___/___/___
l. Ergotamine preparations (Cafegot)		
Yes ___ No ___ I don't recall ___	___/___/___	___/___/___
m. L-tryptophan		
Yes ___ No ___ I don't recall ___	___/___/___	___/___/___
n. Any medication for migraine headaches		
Yes ___ No ___ I don't recall ___	___/___/___	___/___/___

5. Have you used prescription medications (other than fenfluramine (Pondimin), dexfenfluramine (Redux) 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	_____ prescribed by
_____ product	_____ approx. dates of use	_____ prescribed by
_____ product	_____ approx. dates of use	_____ prescribed by

6. Smoking history [check whichever is applicable]

a. never smoked cigarettes _____

b. past smoker of cigarettes _____

date of which smoking ceased _____

amount smoked: _____ packs per day for ____ years

c. current smoker of cigarettes _____

amount smoked: _____ packs per day for ____ years

7. Drinking history

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

Yes _____ No _____

If yes, describe the number of drinks which best represent your greatest alcohol consumption over an extended period.

_____ per day

_____ per week

_____ per month

8. **BEFORE** ingesting fenfluramine (Pondimin), dexfenfluramine (Redux) or phentermine, had you ever experienced any of the following?

a. Shortness of breath not associated with vigorous exercise Yes _____ No _____ I don't recall _____

b. Persistent or recurrent pain in your chest Yes _____ No _____ I don't recall _____

c. Irregular heart beat, including heart palpitations, tachycardia and bradycardia Yes _____ No _____ I don't recall _____

d. Abnormal lack of energy Yes _____ No _____ I don't recall _____

e. Fainting, dizziness or lightheadedness Yes _____ No _____ I don't recall _____

f. Sleep apnea, other sleep breathing disorder, or difficulty breathing Yes _____ No _____ I don't recall _____

g. Snoring Yes _____ No _____ I don't recall _____

h. Head pounding Yes _____ No _____ I don't recall _____

i. Significant swelling of ankles other than during pregnancy Yes _____ No _____ I don't recall _____

j. Memory loss Yes _____ No _____ I don't recall _____

k. Arthritis or joint pain Yes _____ No _____ I don't recall _____

9. **BEFORE** ingesting fenfluramine (Pondimin), dexfenfluramine (Redux) or phentermine, had you ever been told by a doctor or any other person, that you have, may have or had any of the following:

a.	Hypertension or high blood pressure	Yes _____	No _____	I don't recall _____
b.	Heart murmur	Yes _____	No _____	I don't recall _____
c.	Heart attack	Yes _____	No _____	I don't recall _____
d.	Stroke	Yes _____	No _____	I don't recall _____
e.	Blood clot to the lung (pulmonary embolism)	Yes _____	No _____	I don't recall _____
f.	Blood clot in the leg and/or phlebitis	Yes _____	No _____	I don't recall _____
g.	Chronic lung disease	Yes _____	No _____	I don't recall _____
h.	Interstitial parasitic lung disease	Yes _____	No _____	I don't recall _____
i.	Congenital abnormality of heart	Yes _____	No _____	I don't recall _____
j.	Congenital abnormality of lungs, thorax or diaphragm	Yes _____	No _____	I don't recall _____
k.	Hypoxia	Yes _____	No _____	I don't recall _____
l.	Portal hypertension	Yes _____	No _____	I don't recall _____
m.	Pulmonary vasculitis	Yes _____	No _____	I don't recall _____
n.	Immune system disease of dysfunction (including AIDS or HIV)	Yes _____	No _____	I don't recall _____
o.	Rheumatic fever	Yes _____	No _____	I don't recall _____
p.	Cirrhosis, hepatitis or other liver disease	Yes _____	No _____	I don't recall _____
q.	Alcoholism	Yes _____	No _____	I don't recall _____
r.	Carcinoid syndrome	Yes _____	No _____	I don't recall _____
s.	Other cancer If yes, specify: _____	Yes _____	No _____	I don't recall _____
t.	Pulmonary hypertension	Yes _____	No _____	I don't recall _____
u.	Pulmonary venous hypertension	Yes _____	No _____	I don't recall _____
v.	Primary pulmonary hypertension	Yes _____	No _____	I don't recall _____
w.	Heart valve lesions	Yes _____	No _____	I don't recall _____
x.	Heart valve prolapse or regurgitation	Yes _____	No _____	I don't recall _____
y.	Neurological problem If yes, specify: _____	Yes _____	No _____	I don't recall _____
z.	Ankylosing spondylitis	Yes _____	No _____	I don't recall _____
aa.	Altitude heart disease	Yes _____	No _____	I don't recall _____
ab.	Cardiac arrhythmias	Yes _____	No _____	I don't recall _____
ac.	Collagen vascular disease	Yes _____	No _____	I don't recall _____
ad.	Endocarditis	Yes _____	No _____	I don't recall _____
ae.	Eosinophilia-myalgia syndrome (EMS)	Yes _____	No _____	I don't recall _____
af.	High cholesterol	Yes _____	No _____	I don't recall _____
ag.	Hypertriglyceridemia	Yes _____	No _____	I don't recall _____

ah.	Increased levels of low density lipo protein cholesterol (LDL's)	Yes _____	No _____	I don't recall _____
ai.	Marfan's syndrome	Yes _____	No _____	I don't recall _____
aj.	Mediastinal fibrosis	Yes _____	No _____	I don't recall _____
ak.	Mediastinal stenosis	Yes _____	No _____	I don't recall _____
al.	Raynaud's disease	Yes _____	No _____	I don't recall _____
aim.	Anorexia	Yes _____	No _____	I don't recall _____
an.	Bulimia	Yes _____	No _____	I don't recall _____
ao.	Diabetes	Yes _____	No _____	I don't recall _____

If yes, specify type: _____

_____

ap.	Hypoglycemia (low blood sugar)	Yes _____	No _____	I don't recall _____
aq.	Gall bladder disease	Yes _____	No _____	I don't recall _____
ar.	Kidney disease	Yes _____	No _____	I don't recall _____
as.	Dermatomyositis	Yes _____	No _____	I don't recall _____
at.	Lupus	Yes _____	No _____	I don't recall _____
au.	Rheumatoid arthritis	Yes _____	No _____	I don't recall _____
av.	Connective tissue Disease	Yes _____	No _____	I don't recall _____
aw.	Scleroderma	Yes _____	No _____	I don't recall _____
ax.	Other autoimmune disease	Yes _____	No _____	I don't recall _____

If yes, specify: _____

_____

ay.	Scarlet fever	Yes _____	No _____	I don't recall _____
az.	Sickle Cell anemia	Yes _____	No _____	I don't recall _____
ba.	Syphilis	Yes _____	No _____	I don't recall _____
bb.	Thyroid disorder	Yes _____	No _____	I don't recall _____
bc.	Non malignant tumors	Yes _____	No _____	I don't recall _____
bd.	Asthma or emphysema	Yes _____	No _____	I don't recall _____
be.	Coronary artery disease	Yes _____	No _____	I don't recall _____
bf.	Other heart or lung disease	Yes _____	No _____	I don't recall _____
bg.	Gum disease	Yes _____	No _____	I don't recall _____

10. If you responded yes to any of the above, please identify the condition, the date of onset and state the name and the address of the physician or other person who made the diagnosis or informed you of the condition.

a. Condition: _____

Onset: _____

Name and address of diagnosing physician or other person:

_____

b. Condition: _____

Onset: _____

Name and address of diagnosing physician or other person:

_____

c. Condition: _____

Onset: _____

Name and address of diagnosing physician or other person:

_____

d. Condition: _____

Onset: _____

Name and address of diagnosing physician or other person:

_____

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

a. Heart, lung or other chest surgery Yes _____ No _____

For what condition?

_____

When? _____

Treating physician:

_____

b. Treatment for heart attack or angina Yes _____ No _____

For what problem?

_____

When? _____

Treating physician:

_____

c. Pacemaker Yes _____ No _____

When? _____

Treating physician:

_____

d. By-pass surgery Yes _____ No _____

When? _____

Treating physician:

_____

12. Have you ever received any traumatic injury to your chest?

Yes _____ No _____

If yes, state when and describe the injury.

_____ _____

Injury When

13. State whether any of the following tests were administered **BEFORE** your use of fenfluramine (Pondimin), dexfenfluramine (Redux) and/or phentermine.

a.	Echocardiogram	Yes ____	No ____	I don't recall ____
b.	Electrocardiogram	Yes ____	No ____	I don't recall ____
c.	Cardiac or pulmonary artery catheterization	Yes ____	No ____	I don't recall ____
d.	Pulmonary function test	Yes ____	No ____	I don't recall ____
e.	Perfusion lung scan	Yes ____	No ____	I don't recall ____
f.	Chest x-ray	Yes ____	No ____	I don't recall ____
g.	Arterial, cardiac or pulmonary angiogram	Yes ____	No ____	I don't recall ____
h.	Cardio-pulmonary or thallium stress test	Yes ____	No ____	I don't recall ____
i.	Other diagnostic test or imaging of the heart, lungs, or pulmonary arteries or arterial pressure	Yes ____	No ____	I don't recall ____

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

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

15. If an echocardiogram was taken **BEFORE** your use of fenfluramine (Pondimin), dexfenfluramine (Redux) and/or phentermine, complete the following chart as to the results OR attach a copy of the test report. If the diagnosis falls between two categories (e.g. trace to mild), please put a check mark in each of the two categories with a line connecting them:

	None	Trace	Mild	Moderate	Severe
Mitral Valve Regurgitation					
Tricuspid Valve Regurgitation					
Aortic Valve Regurgitation					
Pulmonary Valve Regurgitation					

V: **DIET DRUG USE**

1. Describe each of the drugs which were prescribed for you including the trade name, description, prescribed dosage and frequency, state the period during which such drugs were prescribed, the name of the prescribing physician, the dosage in which you ingested the drugs and the frequency with which you ingested the drugs. For any phentermine product, provide the trade name(s) of the product and a description thereof. If you went on and off a drug a various times or had any change in dosage or frequency, please indicate using a separate line for each period you were prescribed the drug or had a change in dosage or frequency.

Diet drug, Trade name (if any)	Description of the physical appearance of the drug taken (e.g. size, color, shape, markings)	Dosage prescribed	Frequency prescribed (daily)	Date(s) prescribed[1/]	Prescribed by	Dosage taken	Frequency taken (daily)	Approx. dates taken (to - from)
Fenfluramine, Product name: Pondimin	Orange round tablet 20 mg							
Dexfenfluramine, Product name: Redux	White cap with black stripe "REDUX" 15 mg							
Phentermine Product Name: _____								
Phentermine Product name: _____								

1/ These would include if a physician dispensed the drug(s) to you directly (specify which).

2. With respect to each prescription described above state the following as to how the prescription was obtained.

_____ (a) From your own primary care or family physician who wrote a prescription but did not dispense the drugs?
_____ (b) From your own primary care or family physician who dispensed the drugs directly to you?
_____ (c) A physician, other than your primary care or family physician?
_____ (d) A private weight loss clinic?
_____ (e) A hospital-based weight loss clinic or doctor?
_____ (f) Other (e.g., a friend, a pharmacy); please specify

3. State the name and address of any physician, weight loss clinic, or other person who dispensed your fenfluramine (Pondimin), dexfenfluramine (Redux), and/or phentermine, and identify any individuals you spoke with at the pharmacy:

a. Prescription for _____ filled on _____ (date) by (e.g. pharmacy, physician):

_____
Name

_____
Street Address

_____
City, State, Zip

_____
Name of individual(s) you spoke with

b. Prescription for _____ filled on _____ (date) by (e.g. pharmacy, physician):

_____
Name

_____
Street Address

_____
City, State, Zip

_____
Name of individual(s) you spoke with

c. Prescription for _____ filled on _____ (date) by (e.g. pharmacy, physician):

_____
Name

_____
Street Address

_____
City, State, Zip

_____
Name of individual(s) you spoke with

d. Prescription for _____ filled on _____ (date) by (e.g. pharmacy, physician):

_____
Name

_____
Street Address

_____
City, State, Zip

_____
Name of individual(s) you spoke with

4. Did you have the prescription filled yourself? Yes _____ No _____

If you did not fill the prescription, who actually went to the pharmacy or other provider to have the prescription filled?

_____
Name

5. Were you given any written instructions or warnings regarding the use of fenfluramine (Pondimin), dexfenfluramine (Redux) and/or phentermine?

Yes _____ No _____ I don't recall _____

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)

6. Were you given any oral instructions or warnings regarding the use of fenfluramine (Pondimin), dexfenfluramine (Redux) and/or phentermine?

Yes _____ No _____ I don't recall _____

If yes, state when the oral 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)

7. Did you lose weight while on fenfluramine (Pondimin), dexfenfluramine (Redux) and/or phentermine?

_____ Yes _____ No

If the answer is yes, for each course of treatment with the diet drugs, state the amount of weight you lost and state the period during which the weight loss was achieved:

_____ _____
weight lost dates of weight loss

_____ _____
weight lost dates of weight loss

_____ _____
weight lost dates of weight loss

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

High _____lbs. Approximate Date _____

Low _____lbs. Approximate Date _____

VI: CURRENT MEDICAL CONDITION

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

   Yes _____ No _____

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

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

   _____ _____
   Injury, illness or disability Date of diagnosis

   b. By whom first diagnosed:

   _____ _____
   Name Address (if not otherwise provided)

3. At any time AFTER you first ingested fenfluramine (Pondimin), dexfenfluramine (Redux) or phentermine, have you ever experienced any of the following?

   a. Shortness of breath not associated with vigorous exercise Yes _____ No _____ I don't recall _____

   b. Persistent or recurrent pain in your chest Yes _____ No _____ I don't recall _____

   c. Irregular heart beat, including heart palpitations, tachycardia and bradycardia Yes _____ No _____ I don't recall _____

   d. Abnormal lack of energy Yes _____ No _____ I don't recall _____

   e. Fainting, dizziness or lightheadedness Yes _____ No _____ I don't recall _____

   f. Sleep apnea, other sleep breathing disorder, or difficulty breathing Yes _____ No _____ I don't recall _____

   g. Snoring Yes _____ No _____ I don't recall _____

   h. Head pounding Yes _____ No _____ I don't recall _____

   i. Significant swelling of ankles other than during pregnancy Yes _____ No _____ I don't recall _____

   j. Memory loss Yes _____ No _____ I don't recall _____

   k. Arthritis or joint pain Yes _____ No _____ I don't recall _____

4. If you claim psychological or emotional injury as a consequence of diet drugs, state whether you have experienced or been treated for any psychological, psychiatric or emotional problem prior to the use of fenfluramine (Pondimin), dexfenfluramine (Redux) or phentermine.

Yes _____ No _____

If yes, state:

a. Name and address of each person (e.g., psychiatrist, psychologist, social worker) who treated you

(a) _____
Name

_____
Address (if not otherwise provided)

(b) _____
Name

_____
Address (if not otherwise provided)

(c) _____
Name

_____
Address (if not otherwise provided)

b. Condition for which treated

_____

c. When treated

_____

5. **At any time AFTER** you first ingested fenfluramine (Pondimin), dexfenfluramine (Redux) or phentermine, have you ever been told by a doctor or any other person, that you have, may have or had any of the following:

a.	Hypertension or high blood pressure	Yes _____	No _____	I don't recall _____
b.	Heart murmur	Yes _____	No _____	I don't recall _____
c.	Heart attack	Yes _____	No _____	I don't recall _____
d.	Stroke	Yes _____	No _____	I don't recall _____
e.	Blood clot to the lung (pulmonary embolism)	Yes _____	No _____	I don't recall _____
f.	Blood clot in the leg and/or phlebitis	Yes _____	No _____	I don't recall _____
g.	Chronic lung disease	Yes _____	No _____	I don't recall _____
h.	Interstitial parasitic lung disease	Yes _____	No _____	I don't recall _____
i.	Congenital abnormality			

	of heart	Yes _____	No _____	I don't recall _____
j.	Congenital abnormality of lungs, thorax or diaphragm	Yes _____	No _____	I don't recall _____
k.	Hypoxia	Yes _____	No _____	I don't recall _____
l.	Portal hypertension	Yes _____	No _____	I don't recall _____
m.	Pulmonary vasculitis	Yes _____	No _____	I don't recall _____
n.	Immune system disease of dysfunction (including AIDS or HIV)	Yes _____	No _____	I don't recall _____
o.	Rheumatic fever	Yes _____	No _____	I don't recall _____
p.	Cirrhosis, hepatitis or other liver disease	Yes _____	No _____	I don't recall _____
q.	Alcoholism	Yes _____	No _____	I don't recall _____
r.	Carcinoid syndrome	Yes _____	No _____	I don't recall _____
s.	Other cancer	Yes _____	No _____	I don't recall _____
	If yes, specify: _____			
t.	Pulmonary hypertension	Yes _____	No _____	I don't recall _____
u.	Pulmonary venous hypertension	Yes _____	No _____	I don't recall _____
v.	Primary pulmonary hypertension	Yes _____	No _____	I don't recall _____
w.	Heart valve lesions	Yes _____	No _____	I don't recall _____
x.	Heart valve prolapse or regurgitation	Yes _____	No _____	I don't recall _____
y.	Neurological problem	Yes _____	No _____	I don't recall _____
	If yes, specify: _____			
z.	Ankylosing spondylitis	Yes _____	No _____	I don't recall _____
aa.	Altitude heart disease	Yes _____	No _____	I don't recall _____
ab.	Cardiac arrhythmias	Yes _____	No _____	I don't recall _____
ac.	Collagen vascular disease	Yes _____	No _____	I don't recall _____
ad.	Endocarditis	Yes _____	No _____	I don't recall _____
ae.	Eosinophilia-myalgia syndrome (EMS)	Yes _____	No _____	I don't recall _____
af.	High cholesterol	Yes _____	No _____	I don't recall _____
ag.	Hypertriglyceridemia	Yes _____	No _____	I don't recall _____
ah.	Increased levels of low density lipo protein cholesterol (LDL's)	Yes _____	No _____	I don't recall _____
ai.	Marfan's syndrome	Yes _____	No _____	I don't recall _____
aj.	Mediastinal fibrosis	Yes _____	No _____	I don't recall _____
ak.	Mediastinal stenosis	Yes _____	No _____	I don't recall _____
al.	Raynaud's disease	Yes _____	No _____	I don't recall _____
am.	Anorexia	Yes _____	No _____	I don't recall _____
an.	Bulimia	Yes _____	No _____	I don't recall _____
ao.	Diabetes	Yes _____	No _____	I don't recall _____
	If yes, specify type: _____			
ap.	Hypoglycemia (low blood sugar)	Yes _____	No _____	I don't recall _____
aq.	Gall bladder disease	Yes _____	No _____	I don't recall _____
ar.	Kidney disease	Yes _____	No _____	I don't recall _____
as.	Dermatomyositis	Yes _____	No _____	I don't recall _____
at.	Lupus	Yes _____	No _____	I don't recall _____

au.	Rheumatoid arthritis	Yes _____	No _____	I don't recall _____
av.	Connective tissue Disease	Yes _____	No _____	I don't recall _____
aw.	Scleroderma	Yes _____	No _____	I don't recall _____
ax.	Other autoimmune disease	Yes _____	No _____	I don't recall _____
	If yes, specify: _____			
ay.	Scarlet fever	Yes _____	No _____	I don't recall _____
az.	Sickle cell anemia	Yes _____	No _____	I don't recall _____
ba.	Syphilis	Yes _____	No _____	I don't recall _____
bb.	Thyroid disorder	Yes _____	No _____	I don't recall _____
bc.	Non malignant tumors	Yes _____	No _____	I don't recall _____
bd.	Asthma or emphysema	Yes _____	No _____	I don't recall _____
be.	Coronary artery disease	Yes _____	No _____	I don't recall _____
bf.	Other heart or lung disease	Yes _____	No _____	I don't recall _____
bg.	Gum disease	Yes _____	No _____	I don't recall _____

6. 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 person and the address of the physician who made the diagnosis or informed you of the condition.

a. Condition: _____

Onset: _____

Name and address of diagnosing physician or other person:

_____

b. Condition: _____

Onset: _____

Name and address of diagnosing physician or other person:

_____

c. Condition: _____

Onset: _____

Name and address of diagnosing physician or other person:

_____

d. Condition: _____

Onset: _____

Name and address of diagnosing physician or other person:

_____

7. State whether any of the following tests were administered **at any time AFTER** you first ingested fenfluramine (Pondimin), dexfenfluramine (Redux) and/or phentermine.

a.	Echocardiogram	Yes ____	No ____	I don't recall ____
b.	Electrocardiogram	Yes ____	No ____	I don't recall ____
c.	Cardiac or pulmonary artery catheterization	Yes ____	No ____	I don't recall ____
d.	Pulmonary function test	Yes ____	No ____	I don't recall ____
e.	Perfusion lung scan	Yes ____	No ____	I don't recall ____
f.	Chest x-ray	Yes ____	No ____	I don't recall ____
g.	Arterial, cardiac or pulmonary angiogram	Yes ____	No ____	I don't recall ____
h.	Cardio-pulmonary or thallium stress test	Yes ____	No ____	I don't recall ____
i.	Other diagnostic test or imaging of the heart, lungs, or pulmonary arteries or arterial pressure	Yes ____	No ____	I don't recall ____

8. For each test for which you answered yes, identify the physician and approximate date on which the tests were done.

Test	Physician	Approximate date

9. If an echocardiogram was taken **at any time AFTER** you first ingested fenfluramine (Pondimin), dexfenfluramine (Redux) and/or phentermine, complete the following chart as to the results **OR** attach a copy of the test results. If the diagnosis falls between two categories (e.G. trace to mild) please put check marks in both categories with a line between the two:

	None	Trace	Mild	Moderate	Severe
Mitral Valve Regurgitation					
Tricuspid Valve Regurgitation					
Aortic Valve Regurgitation					
Pulmonary Valve Regurgitation					

VII: INJURY CLAIMS

1. a. Excluding discussions with experts hired by your attorney, have you had discussions with any treating physician about whether your condition is related to the use of diet drugs?

   Yes _____ No _____ I don't recall _____

   b. If yes, identify the doctor or doctors

   _____
   Name

   _____
   Address (if not otherwise provided)

   c. 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 or she does not know whether my condition is related to the use of diet drugs ____.

   (e) I don't recall what I was told ___.

   d. If discussed with more than one doctor, please copy and complete Parts b and c for each on additional sheets.

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

a. 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

b. 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.

_____

_____

c. To the best of your knowledge, state your earned income for each of the last five years.

Year Income

_____ $_____
_____ $_____
_____ $_____
_____ $_____
_____ $_____

PART VIII: MISCELLANEOUS

1. Have you been in communication with any of the parties (other than the physician or health care providers) you have sued in this case?

Yes _____ No _____

2. If you answered "Yes" to the previous question, please provide the following information for each such communication:

a. _____
Defendant with whom you communicated

_____
Date and method of communication (e.g. telephone, office visit, letter, e-mail)

_____
Substance of the communication

_____

_____
Witness(es) to the communication

b. _____
Defendant with whom you communicated

_____
Date and method of communication (e.g. telephone, office visit, letter, e-mail)

_____
Substance of the communication

_____

_____
Witness(es) to the communication

c. _____
Defendant with whom you communicated

_____
Date and method of communication (e.g. telephone, office visit, letter, e-mail)

_____
Substance of the communication

_____

_____
Witness(es) to the communication

3. To the best of your ability, provide the following information to the extent it has not previously been provided in the questionnaire.

A. Identify your **current primary care or family physician or clinic:**

Name

Street Address

City, State, Zip Code

B. Identify each of your **primary care or family physicians or clinics** for the last twenty years.

1.

Name

Street Address

City, State, Zip Code

Approximate dates

2.

Name

Street Address

City, State, Zip Code

Approximate dates

C. Identify each **pediatrician** who examined or treated you as a child.

1.

Name

Street Address

City, State, Zip Code

Approximate dates

2.

Name

Street Address

City, State, Zip Code

Approximate dates

D. Identify each cardiologist, pulmonary physician and/or **heart, lung or chest surgeon** who has ever seen or treated you.

1.

Name

Specialty

Street Address

City, State, Zip Code

2.

Name

Specialty

Street Address

City, State, Zip Code

3.

Name

Specialty

Street Address

City, State, Zip Code

4.

Name

Specialty

Street Address

City, State, Zip Code

E. Identify each **hospital** where you have received **inpatient** treatment during the last twenty years.

1.

Name

Specialty

Street Address

City, State, Zip Code

2.

Name

Specialty

Street Address

City, State, Zip Code

3.

Name

Specialty

Street Address

City, State, Zip Code

4.

Name

Specialty

Street Address

City, State, Zip Code

F. Identify each **hospital or health care facility** where you have received **outpatient** treatment (including treatment in an emergency room) during the last twenty years.

1.

Name

Specialty

Street Address

City, State, Zip Code

2.

Name

Specialty

Street Address

City, State, Zip Code

3.

Name

Specialty

Street Address

City, State, Zip Code

4.

Name

Specialty

Street Address

City, State, Zip Code

G. Identify each other **physician or health care provider** from whom you have received treatment during the last twenty years with the exception of psychiatrists or psychologists.

1.

Name

Specialty

Street Address

City, State, Zip Code

2.

Name

Specialty

Street Address

City, State, Zip Code

3.

Name

Specialty

Street Address

City, State, Zip Code

4.

Name

Specialty

Street Address

City, State, Zip Code

5.

Name

Specialty

Street Address

City, State, Zip Code

6.

Name

Specialty

Street Address

City, State, Zip Code

7.

Name

Specialty

Street Address

City, State, Zip Code

8.

Name

Specialty

Street Address

City, State, Zip Code

H. Identify each **pharmacy, drugstore** and the like where you have had prescriptions filled during the past twenty years or from which you have ever received any prescription medication taken to control or reduce your weight:

1.

Name

Street Address

City, State, Zip Code

2.

Name

Street Address

City, State, Zip Code

3.

Name

Street Address

City, State, Zip Code

4.

Name

Street Address

City, State. Zip Code

5.

Name

Street Address

City, State, Zip Code

**[ATTACH ADDITIONAL SHEETS,
IF NECESSARY TO COMPLETE EACH SUBSECTION]**

IX: DOCUMENTS

If you have or have given to your attorneys any of the following documents, you (or your attorney) must attach them to this declaration. This shall include documents which you have previously provided to your attorney, but does not include documents that your attorney has independently gathered.

1. A copy of the prescription, drugstore printout(s) including any "patient prescription profile", physician or office record, drug containers, brochures, patient information, or any other record showing each diet drug which you have taken, the period during which you have taken each such diet drug, the dosage of each of such diet drug, the frequency with which you took each such drug, and any information you were given about the diet drug.

☐ I have no documents responsive to this request.
☐ The responsive documents are attached.
☐ The responsive documents will be produced by _____
(date)

2. All documents evidencing or otherwise relating to the purchase of fenfluramine (Pondimin), dexfenfluramine (Redux) and/or phentermine for use by the plaintiff.

☐ I have no documents responsive to this request.
☐ The responsive documents are attached.
☐ The responsive documents will be produced by _____
(date)

3. All documents evidencing or otherwise relating to any diagnostic tests referenced in this questionnaire, including without limitation, each report of any echocardiogram which has been performed on you at any time.

☐ I have no documents responsive to this request.
☐ The responsive documents are attached.
☐ The responsive documents will be produced by _____
(date)

4. All medical records from any physician, hospital, or other health care provider who treated you at any time for any disease, condition, or symptom included in this questionnaire.

☐ I have no documents responsive to this request.
☐ The responsive documents are attached.
☐ The responsive documents will be produced by _____
(date)

5. To the extent not included in the foregoing, all records relating to any examination by a physician or other health care provider, conducted for any purpose, other than psychiatric or psychological evaluation, in the period beginning five (5) years prior to the date upon which you first used phentermine, fenfluramine (Pondimin) or dexfenfluramine (Redux) and continuing to the present date.

☐ I have no documents responsive to this request.
☐ The responsive documents are attached.
☐ The responsive documents will be produced by _____
(date)

6. 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.

☐ I have no documents responsive to this request.
☐ The responsive documents are attached.
☐ The responsive documents will be produced by _____
(date)

7. All personal diaries, calendars, date books or other documents, including recordations which reflect any facts or information regarding your use of fenfluramine (Pondimin), dexfenfluramine (Redux) and/or phentermine or any alleged complaint, symptom, adverse reaction or other injury allegedly arising therefrom.

☐ I have no documents responsive to this request.
☐ The responsive documents are attached.
☐ The responsive documents will be produced by _____
(date)

8. If you claim wage loss or impairment in earning capacity as a result of taking fenfluramine (Pondimin), dexfenfluramine (Redux) and/or phentermine, copies of all your W-2 statements (or if you are self-employed, federal income tax returns) for a period from three years prior to the date on which you first took fenfluramine (Pondimin) , dexfenfluramine (Redux) and/or phentermine through the present.

☐ I have no documents responsive to this request.
☐ The responsive documents are attached.
☐ The responsive documents will be produced by _____
(date)

9. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider and copies of any insurance including Medicaid/Medicare claims or proceeds.

☐ I have no documents responsive to this request.
☐ The responsive documents are attached.
☐ The responsive documents will be produced by _____
(date)

10. Copies of 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.

☐ I have no documents responsive to this request.
☐ The responsive documents are attached.
☐ The responsive documents will be produced by _____
(date)

11. Copies of any and all statements from any defendant made to the plaintiff, his agents, servants or representatives.

☐ I have no documents responsive to this request.
☐ The responsive documents are attached.
☐ The responsive documents will be produced by _____
(date)

12. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, height and weight charts, pharmacy handouts or other materials distributed with or provided to you when your prescriptions for diet medications were filled.

☐ I have no documents responsive to this request.
☐ The responsive documents are attached.
☐ The responsive documents will be produced by _____
(date)

13. All documents in the nature of records regarding weight gain and weight loss such as charts recording weight loss, diaries of weight loss efforts, notes or descriptions of medicines or other substances used to control or reduce your weight and the like.

☐ I have no documents responsive to this request.
☐ The responsive documents are attached.
☐ The responsive documents will be produced by _____
(date)

14. Copies of all advertisements or promotions for diet drugs.

☐ I have no documents responsive to this request.
☐ The responsive documents are attached.
☐ The responsive documents will be produced by _____
(date)

15. If you allege a claim of loss of consortium, a copy of your marriage certificate.

☐ I have no documents responsive to this request.
☐ The responsive documents are attached.
☐ The responsive documents will be produced by _____
(date)

16. If you represent a decedent, a copy of the death certificate.

☐ I have no documents responsive to this request.
☐ The responsive documents are attached.
☐ The responsive documents will be produced by _____
(date)

PART X: AUTHORIZATIONS

ORIGINAL SIGNED AUTHORIZATIONS

Provide signed, notarized original authorizations using the enclosed forms [you should make additional copies to the extent needed] for the following:

1. Each health care provider, hospital or other medical institution you have identified in response to the questions set forth in this questionnaire for the release of records pertaining to you.

2. Each pharmacy you have identified in response to the questions set forth in this questionnaire for the release of records pertaining to you.

3. Each of your present and past employers identified in response to the questions set forth in this questionnaire for the release of records pertaining to you. If you are self-employed and are claiming lost earnings or impaired earning capacity, provide release forms for the Internal Revenue Service for release of your tax returns for each of the last five years (together with copies of two forms of signature identification).

4. Each worker's compensation or social security disability institution or office at which you have filed a claim (as identified in questions II. 10 and 11 of this questionnaire) for records pertaining to you.

IMPORTANT NOTE: Provide ONE authorization for each medical professional, pharmacy employer or other institution, unless you have sued a physician or other health care professional, in which case you must provide TWO authorizations for each medical professional, pharmacy employer or other institution.

MEDICAL RECORDS RELEASE

TO:

This Authorization permits you to release copies of all records and information that you made or have in connection with the examinations, diagnoses and treatments of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your medical treatment of me. It does not permit you to be interviewed regarding my treatment, to give any statements or supply any narrative reports.

The undersigned hereby authorizes you to give to the

_____ or any of their representatives

presenting the original or photostatic copy hereof, copies of any and all records regarding the undersigned's medical condition and medical expenses. This information includes, but is not limited to, matters regarding the undersigned's injuries, diseases, diagnoses and treatments. The information to be released includes, but is not limited to: medical records, reports, x-rays, echocardiographic recordings, other diagnostic tests or films, prescription records, medical bills. These records may be used in a civil litigation matter filed by the undersigned.

Dated this _____ day of _____, 199__.

_____
Signature of Plaintiff

_____
Type or Print Name

_____
Date of Birth

_____
Social Security Number

SUBSCRIBED AND SWORN TO BEFORE ME IN MY PRESENCE
this _____ day of _____, 1998.

_____
Notary Public

My Commission expires _____

AUTHORIZATION
TO RELEASE PHARMACY RECORDS

TO:

The undersigned hereby authorizes you to give to the attorneys requesting this information or their representatives presenting the original or photostatic copy hereof, copies of any and all records of the pharmacy or pharmacy department concerning me, including but not limited to all prescription records, patient profile records, backs of the prescriptions, third-party payor information and/or any similar records.

Dated this _____ day of _____, 199__.

_____
Signature of Plaintiff

_____
Type or Print Name

_____
Date of Birth

_____
Social Security Number

SUBSCRIBED AND SWORN TO BEFORE ME IN MY PRESENCE
this _____ day of _____, 1998.

_____
Notary Public

My Commission expires _____

AUTHORIZATION FROM EMPLOYEE
TO RELEASE EMPLOYMENT INFORMATION

TO:

The undesigned hereby authorizes you to provide to the attorneys requesting this information or their representatives presenting the original or photostatic copy hereof, copies of any and all employment records pertaining to the undersigned, including without limitation: applications for employment; reports of any physical examinations; transfers, promotions, wage increases and decreases, and all other materials and documents contained in my personnel file with you; all earnings, wage and income statements and documents relating thereto; all documents relating to discipline including warnings, reprimands, suspensions, terminations and all other forms of discipline; all performance reviews and job evaluations; all dates of employment, absences and dates of termination and all documents relating to discharge and/or termination; and all documents relating to my absences, illness and injuries.

Dated this _____ day of _____, 199__.

_____
Signature of Plaintiff

_____
Type or Print Name

_____
Date of Birth

_____
Social Security Number

SUBSCRIBED AND SWORN TO BEFORE ME IN MY PRESENCE
this _____ day of _____, 1998.

_____
Notary Public

My Commission expires _____

AUTHORIZATION
TO RELEASE CLAIM INFORMATION

TO:

This undersigned hereby authorizes you to provide to the attorneys requesting this information or their representatives presenting the original or photostatic copy hereof, copies of any and all documents and records pertaining in any way to any claim made by the undersigned for worker's compensation, disability or other benefits, including without limitation: all records pertaining to the cost of medical care or rehabilitation for which reimbursement has been made or it is reasonably anticipated in the future will be made, from any collateral benefit programs, or any other organization or program; all records of payments, payroll stubs; any correspondence to or from any person; any analysis(es) of claimant's medical condition; all analysis(es) of any disability or claimed disability and any entitlements to disability payments; and all documents related to the termination of any payments, insurance coverage and/or benefits.

Dated this _____ day of _____, 199__.

_____
Signature of Plaintiff

_____
Type or Print Name

_____
Date of Birth

_____
Social Security Number

SUBSCRIBED AND SWORN TO BEFORE ME IN MY PRESENCE
this _____ day of _____, 1998.

_____
Notary Public

PLAINTIFF'S DECLARATION

I declare under penalty of perjury that all the information provided in this Plaintiffs' Initial Discovery is true and correct to the best of my knowledge, information and belief and that I have supplied all the documents requested to the extent that such documents are in my possession, control or custody and that I have supplied the authorizations as requested.

Date: _____ Signed: _____

Print Name: _____

SUBSCRIBED AND SWORN TO BEFORE ME IN MY PRESENCE
this _____ day of _____, 1998.

_____
Notary Public

My Commission expires _____