

**IN RE CALIFORNIA COORDINATED DIET DRUG PROCEEDINGS
JCCP-4032**

PLAINTIFF'S FACT SHEET

This Fact Sheet and the attached List of Medical Providers and Other Sources of Information must be completed by each plaintiff in JCCP-4032 who used diet drugs or who is the representative of a person or the estate of a deceased person who used diet drugs.

I. CASE INFORMATION

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

1. Case Caption: _____

2. JCCP Civil Action No.: _____

3. Court in which action originally brought (transferor district):

4. Original civil action number in the transferor court.

Civil Action No.: _____

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

Name

Firm

City, State and Zip Code

Telephone number

Fax number

E-mail address

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

2. If the answer to the foregoing questions is "Yes", state the nature of the injury or injuries which you claim.

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

II. PERSONAL INFORMATION

A. Last Name: _____

First Name: _____

Middle Name or Initial: _____

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

C. Present Street Address: _____

City State Zip Code

D. Current or last employer:

Name

Address

Dates of Employment

Occupation

E. Social Security Number: _____

F. Date of Birth: _____

G. Sex: Male _____ Female _____

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

Yes _____ No _____

If Yes, please state:

1. What branch and the dates of service.
2. Were you discharged for any reason relating to your health or physical condition?

Yes _____ No _____

If yes, state what that condition was.

I. 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.

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

Yes _____ No _____

If yes, please state

1. Year claim was filed: _____

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

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

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

Yes _____ No _____

If yes, please state

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

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

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

Yes _____ No _____

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

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

Yes _____ No _____

III. FAMILY INFORMATION

A. Are you currently married?

Yes _____ No _____

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

Yes _____ No _____

C. Spouse's name: _____

D. Spouse's date of birth: _____

E. Spouse's occupation: _____

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

Yes _____ No _____ I Don't know _____

If yes, identify each such person below and provide the information requested.

1. Name _____

Current Age (or Age at Death) _____

Type of Problem _____

If Applicable, Cause of Death _____

2. Name _____

Current Age (or Age at Death) _____

Type of Problem _____

If Applicable, Cause of Death _____

3. Name _____

Current Age (or Age at Death) _____

Type of Problem _____

If Applicable, Cause of Death _____

IV. CURRENT MEDICAL CONDITION

A. Do you currently suffer from any physical injuries, illnesses or disabilities (other than those you claim are caused by the ingestion of Pondimin, Redux and/or phentermine)?

Yes _____ No _____

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

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

_____ Date of onset _____
Injury, illness or disability

2. By whom first diagnosed:

_____ Address (if not otherwise provided)
Name

V. MEDICAL BACKGROUND

A. Height: _____

B. Weight before use of Pondimin, Redux or phentermine:

C. Current weight: _____

D. To the best of your knowledge, have you ever used any of the following?

Substance Date First Taken Date Last Taken

1. Oral contraceptives

Yes ___ No ___ ___/___/___ ___/___/___

2. Antidepressants

Yes ___ No ___ ___/___/___ ___/___/___

Substance Date First Taken Date Last Taken

3. Heart medications

Yes ___ No ___ ___/___/___ ___/___/___

4. Blood pressure medication

Yes ___ No ___ ___/___/___ ___/___/___

5. Thyroid supplements

Yes ___ No ___ ___/___/___ ___/___/___

6. Diuretics

Yes ___ No ___ ___/___/___ ___/___/___

7. Non-prescription intravenous injections

Yes ___ No ___ ___/___/___ ___/___/___

8. Any use of cocaine, crack cocaine, or heroin or use of marijuana on more than 4 occasions

Yes ___ No ___ ___/___/___ ___/___/___

9. Amphetamines

Yes ___ No ___ ___/___/___ ___/___/___

10. Inhaled non-prescription substance (e.g., inhalation of glue or toluene)

Yes ___ No ___ ___/___/___ ___/___/___

11. Methysergide (Sansert)

Yes ___ No ___ ___/___/___ ___/___/___

12. Ergotamine preparations (Cafergot)

Yes ___ No ___ ___/___/___ ___/___/___

Substance Date First Taken Date Last Taken

13. L-tryptophan

Yes ___ No ___ ____/____/____ ____/____/____

14. Any medication for migraine headaches

Yes ___ No ___ ____/____/____ ____/____/____

If yes, identify the medication

E. To the best of your knowledge, have you used prescription medications (other than Pondimin, 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

_____ _____
product approx. dates of use

_____ _____
product approx. dates of use

F. Smoking history [check whichever is applicable]

1. never smoked cigarettes _____

2. past smoker of cigarettes _____

date on which smoking ceased _____

amount smoked: ____ packs per day for ____ years

3. current smoker of cigarettes _____

amount smoked: ____ packs per day for ____ years

G. Drinking history

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

Yes _____ No _____

If yes, check the following box which represents your greatest alcohol consumption over the last five (5) years.

_____ 1-5 drinks per week

_____ 6-10 drinks per week

_____ 15 or more drinks per week

H. To the best of your knowledge, have you ever experienced any of the following?

1. Shortness of breath not associated with vigorous exercise Yes _____ No _____
2. Persistent or recurrent pain in your chest Yes _____ No _____
3. Irregular heart beat, including heart palpitations, tachycardia and bradycardia Yes _____ No _____
4. Abnormal lack of energy Yes _____ No _____
5. Fainting, dizziness or lightheadedness Yes _____ No _____
6. Sleep apnea, other sleep breathing disorder, or difficulty breathing Yes _____ No _____
7. Snoring Yes _____ No _____
8. Head pounding Yes _____ No _____
9. Significant swelling of ankles other than during pregnancy Yes _____ No _____
10. Memory loss Yes _____ No _____
11. Arthritis or joint pain Yes _____ No _____

I. If you claim **neurotoxic injury or a claim for mental or emotional injury over and above that usually associated with the physical injuries claimed** as a result of your ingestion of diet drugs, state whether you have experienced or been treated for any psychological, psychiatric or emotional problem prior to the use of Pondimin, Redux or phentermine.

Yes ___ No _____

If yes, state:

1. Name and address of each person who treated you

a. _____
Name

Address (if not otherwise provided)

b. _____
Name

Address (if not otherwise provided)

c. _____
Name

Address (if not otherwise provided)

2. Condition for which treated

3. When treated

J. To the best of your knowledge, have you ever been told by a doctor or any other health care provider, that you have, may have or had any of the following:

1. Hypertension or high blood pressure Yes ___ No ___

2. Heart murmur Yes ___ No ___

3. Heart attack Yes ___ No ___

4. Stroke Yes ___ No ___

5. Blood clot to the lung
(pulmonary embolism) Yes ___ No ___

6. Blood clot in the leg and/or phlebitis Yes ___ No ___

7. Chronic lung disease Yes ___ No ___

8. Interstitial parasitic lung disease Yes ___ No ___
9. Congenital abnormality of heart Yes ___ No ___
10. Congenital abnormality of lungs, thorax or diaphragm Yes ___ No ___
11. Hypoxia Yes ___ No ___
12. Portal hypertension Yes ___ No ___
13. Pulmonary vasculitis Yes ___ No ___
14. Immune system disease or dysfunction (including Aids or HIV) Yes ___ No ___
15. Rheumatic fever Yes ___ No ___
16. Cirrhosis, hepatitis or other liver disease Yes ___ No ___
17. Alcoholism Yes ___ No ___
18. Carcinoid syndrome Yes ___ No ___
19. Other Cancer Yes ___ No ___
If yes, specify: _____
-
20. Pulmonary hypertension Yes ___ No ___
21. Pulmonary venous hypertension Yes ___ No ___
22. Primary pulmonary hypertension Yes ___ No ___
23. Heart valve lesions Yes ___ No ___
24. Heart valve prolapse or regurgitation Yes ___ No ___
25. Neurological problem Yes ___ No ___
If yes, specify: _____
-
26. Ankylosing spondylitis Yes ___ No ___
27. Altitude heart disease Yes ___ No ___
28. Cardiac arrhythmias Yes ___ No ___
29. Collagen vascular disease Yes ___ No ___
30. Endocarditis Yes ___ No ___
31. Eosinophilia-myalgia syndrome (EMS) Yes ___ No ___
32. High cholesterol Yes ___ No ___
33. Hypertriglyceridemia Yes ___ No ___
34. Increased levels of low density lipo protein cholesterol (LDL's) Yes ___ No ___
35. Marfan's Syndrome Yes ___ No ___
36. Mediastinal Fibrosis Yes ___ No ___
37. Mediastinal Stenosis Yes ___ No ___
38. Raynaud's Disease Yes ___ No ___
39. Anorexia Yes ___ No ___
40. Bulimia Yes ___ No ___
41. Diabetes mellitus or other form of diabetes Yes ___ No ___
If yes, specify the type: _____
-
42. Hypoglycemia (low blood sugar) Yes ___ No ___
-
43. Gall bladder disease Yes ___ No ___

- | | | |
|-------|-----------------------------|----------------|
| 44. | Kidney disease | Yes ___ No ___ |
| 45. | Dermatomyositis | Yes ___ No ___ |
| 46. | Lupus | Yes ___ No ___ |
| 47. | Rheumatoid Arthritis | Yes ___ No ___ |
| 48. | Connective Tissue Disease | Yes ___ No ___ |
| 49. | Scleroderma | Yes ___ No ___ |
| 50. | Other autoimmune disease | Yes ___ No ___ |
| | If Yes, specify: _____ | |
| _____ | | |
| 51. | Scarlet fever | Yes ___ No ___ |
| 52. | Sickle Cell Anemia | Yes ___ No ___ |
| 53. | Syphilis | Yes ___ No ___ |
| 54. | Thyroid disorder | Yes ___ No ___ |
| 55. | Non Malignant Tumors | Yes ___ No ___ |
| 56. | Asthma or emphysema | Yes ___ No ___ |
| 57. | Coronary artery disease | Yes ___ No ___ |
| 58. | Other heart or lung disease | Yes ___ No ___ |
| 59. | Gum disease | Yes ___ No ___ |

K. 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, if not provided in the accompanying list, the address of the physician who made the diagnosis or informed you of the condition.

1. Condition: _____

Onset: _____

Name and address of diagnosing physician or other person:

2. Condition: _____

Onset: _____

Name and address of diagnosing physician or other person:

3. Condition: _____

Onset: _____

Name and address of diagnosing physician or other person:

4. Condition: _____

Onset: _____

Name and address of diagnosing physician or other person:

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

1. Heart, lung or other chest surgery Yes ___ No ___

For what condition?

When? _____

Treating physician:

2. Treatment for heart attack or angina Yes ___ No ___

For what problem?

When? _____

Treating physician:

3. Pacemaker Yes ___ No ___

When?

Treating physician:

P. If an echocardiogram was taken **BEFORE** your use of Pondimin, Redux and/or phentermine, complete the following chart as to the results or attach a copy of the test report:

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

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

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

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

Treating Physician

Approximate date

S. If an echocardiogram was taken **AFTER** your use of Pondimin, Redux and/or phentermine, complete the following chart as to the results or attach a copy of the test results:

None Trace Mild Moderate Severe

Mitral Valve Regurgitation _____
 Tricuspid Valve Regurgitation _____
 Aortic Valve Regurgitation _____
 Pulmonary Valve Regurgitation _____

VI. DIET DRUG USE

A. Please complete the following chart with respect to each diet medication you have taken: (if you took more than one type of phentermine product, please complete this chart, including a description, for each separate phentermine product].

Drug Name: Generic/Brand	Description: Color/Shape/Writing/Name	Approximate Date First Taken	Approximate Date Last Taken	Prescribed/Dispensed by: (Doctor or Clinic)
dexfenfluramine/Redux	15 mg. capsule; white cap with black stripe; "REDUX"			
fenfluramine/Pondimin	orange round tablet; 20 mg.			
phentermine				
phentermine				
phentermine				

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

1. Brand Name: _____

Manufacturer/Distributor _____

2. Brand Name: _____

Manufacturer/Distributor _____

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

product which you took.

1. white capsule with blue cap; "Adipex-P" - "37.5" on cap and two dark stripes on body _____
2. white caplet with blue spots; 37.5 mg.; "LEMMON" - "99" with center score _____
3. Peanut shaped, green tablet imprinted with "S" on both sides; 37.5 mg. _____
4. 30 mg.; blue and clear capsule with blue and white beads; imprinted with "BMP 147," "Fastin" and/or "Beecham" _____
5. white tablet with blue dots; oval; 37.5 mg. _____
6. green round tablet; 8 mg. _____
7. orange round tablet; 8 mg. _____
8. yellow oblong tablet; 37.5 mg. _____
9. black-yellow capsule; 37.5 mg. _____
10. black-black capsule; 37.5 mg. _____
11. brown-clear capsule; 37.5 mg. _____
12. green-clear capsule; 37.5 mg. _____
13. red-black capsule; 37.5 mg. _____
14. yellow-yellow capsule; 37.5 _____
15. yellow-yellow capsule; 30 mg. _____
16. green-clear capsule; 30 mg. _____
17. brown-clear capsule; 30 mg. _____
18. black-black capsule; 30 mg. _____
19. blue-clear capsule; 30 mg. _____

- 20. gray-yellow capsule; 15 mg. _____
- 21. yellow-gray capsule: 18.75 mg. imprinted "18.75" _____
- 22. yellow-gray capsule; 15 mg.; imprinted "E882" _____
- 23. yellow-yellow capsule; 30 mg.; imprinted "E647" _____
- 24. blue-white gel capsule; "E5000"; 30 mg. _____
- 25. 37.5 mg. tablet with blue dots _____
- 26. Resin; yellow-Yellow capsule imprinted with "IONAMIN 30" _____
- 27. Resin; yellow-gray capsule imprinted with "IONAMIN 15" _____
- 28. Hard yellow gel capsule; 30 mg.; "RPC-69" _____
- 29. green-clear gel capsule; 37.5 mg.; imprinted "ABANA" and "217" _____
- 30. black capsule _____
- 31. yellow capsule _____
- 32. yellow-gray capsule _____
- 33. blue-clear capsule _____
- 34. black gel capsule; 30 mg.; imprinted "Zantryl" _____
- 35. Other: _____

Please describe: _____

- 36. I can't remember what the product looked like _____
- D. For each diet drug used by you, set forth the approximate date of any product change or any change or interruption in dosage.

Product Dosage Change/Interruption/
Product Change Approximate Date

Product Dosage Change/Interruption/
Product Change Approximate Date

Product Dosage Change/Interruption/
Product Change Approximate Date

E. Did you lose weight while on Pondimin, Redux or Phentermine?

_____ Yes _____ No

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

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

High _____ lbs. Approximate Date _____

Low _____ lbs. Approximate Date _____

VII. INJURY CLAIMS

A. 1. Have you had discussions with any doctor about whether your condition is related to the use of diet drugs?

Yes _____ No _____ Don't Know _____

2. If yes, check one of the following:

a. I was told my condition is related to the use of diet drugs _____.

b. I was told my condition is not related to the use of diet drugs _____.

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

3. Identify the doctor or doctors

Name

Address (if not otherwise provided)

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

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

Yes_____ No_____

If yes, identify the drug requested _____

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

Yes_____ No_____

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

Approximate date

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

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

Yes _____ No _____

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

Approximate date

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

- E. If you claim or expect to claim that you lost earnings or impairment of earning capacity as a result of any condition which you believe was caused by your use of diet drugs:
1. Complete the following information with respect to your employment for the past ten years.

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

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

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

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

- F. Have you paid or incurred any medical expenses, including amounts billed or paid by insurers and other third party payors, which are related to any condition which you claim or believe was caused by your use of diet drugs and for which you seek recovery in the action which you have filed?

Yes _____ No _____

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

VIII. DOCUMENTS

Attach the following documents to this declaration, to the extent that such documents are currently in your possession or in the possession of your lawyers.

- A. A copy of all prescriptions for diet medications, exemplars of any unused diet medications you received as a result of such prescriptions, receipts, physician or office records, drug containers, packaging and other records which show each diet drug you have taken, the period during which you have taken each, the dosage of each diet drug and the frequency with which you took each drug.
- B. A copy of all medical records from any physician hospital or health care provider, who treated you for any disease, condition or symptom referred to in your response to questions in Part V.
- C. 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, Pondimin or Redux and continuing to date.
- D. 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.
- E. All diagnostic tests or test results including reports of echocardiograms.
- F. Copies of all documents from physicians, health or weight loss clinics or others relating to the use of diet drugs, or to any condition you claim is related to the use of diet drugs.
- G. 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.

- H. 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. Copies of all advertisements or promotions for diet drugs.
- J. If you claim you have suffered a loss of earnings or earning capacity, all documents, excluding federal tax returns, which support such claim.
- K. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider.

DECLARATION

I declare under penalty of perjury under the laws of the State of California that all of the information provided in this Fact Sheet is true and correct to the best of my knowledge, information and belief, that I have completed the List of Medical Providers and Other Sources of Information appended hereto, which is true and correct to the best of my knowledge, information and belief, that I have supplied all the documents requested in part VII of this declaration, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied the authorizations attached to this declaration.

Signature

Date

**IN RE CALIFORNIA COORDINATED DIET DRUG PROCEEDINGS
JCCP-4032**

**LIST OF MEDICAL PROVIDERS
AND OTHER SOURCES OF INFORMATION**

EACH PLAINTIFF IN JCCP 4032 WHO IS REQUIRED TO COMPLETE A DECLARATION MUST FULLY AND ACCURATELY COMPLETE THIS FORM LISTING MEDICAL CARE PROVIDERS AND OTHER SOURCES OF INFORMATION AS REQUESTED.

List the name and address of each of the following:

A. Your current family physician:

Name

Street Address

City, State, Zip Code

B. To the best of your ability, identify each of your primary care physicians **going back to birth**.

1.

Name

Approximate dates

Last known address

City, State, Zip Code

2.

Name

Approximate dates

Last known address

City, State, Zip Code

3.

Name

Approximate dates

Last known address

City, State, Zip Code

4.

Name

Approximate dates

Last known address

City, State, Zip Code

C. 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

D. Each **hospital** where you have ever received **inpatient** treatment.

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

E. Each **hospital or healthcare facility** where you ever received **outpatient** treatment (including treatment in an emergency room).

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

F. Each other **physician** or **healthcare provider** from whom you ever received treatment 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

9.

Name

Specialty

Street Address

City, State, Zip Code

10.

Name

Specialty

Street Address

City, State, Zip Code

G. Each pharmacy, drugstore and the like where you received any prescription medication taken to control or reduce your weight:

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

H. **If but only if** you claim that you suffered neurotoxic injury or mental or emotional injury over and above that usually associated with the physical injuries claimed as a result of taking diet drugs, list each **psychiatrist, psychologist and/or social worker** from whom you ever received treatment.

1.

Name

Street Address

City, State, Zip Code

2.

Name

Street Address

City, State, Zip Code

3.

Name

Street Address

City, State, Zip Code

I. If you ever submitted a claim **for social security disability benefits**, state the name and address of the office which is most likely to have records concerning your claim.

Name

Street Address

City, State, Zip Code

J. If you ever submitted a claim for **worker's compensation**, state the name and address of the office which is most likely to have records concerning your claim.

Name

Street Address

City, State, Zip Code

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