UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS

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| **IN RE: TESTOSTERONE REPLACEMENT****THERAPY PRODUCTS LIABILITY****LITIGATION** | **Case No. 1:14-CV-01748****MDL 2545** |
| **This document relates to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **JUDGE MATTHEW F. KENNELLY** |

PLAINTIFF FACT SHEET

Plaintiff’s Name:

Please provide the following information for each individual on whose behalf a claim is being made. If you are completing this questionnaire in a representative capacity, please respond to all questions with respect to the person who was treated with Testosterone Replacement Therapy (“TRT”). Those questions using the term “**You**” refer to the person who was treated with TRT.

If you do not have enough room on this Fact Sheet form to fit your complete response to any question or request, please either complete that response on a supplemental page, or on additional copies of the pages for which you need more room.

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

(1) “**Healthcare provider**” means any hospital, clinic, center, physician’s, infirmary, medical or diagnostic laboratory, or other facility that provides healthcare, including, but not limited to, medical, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, mental health care professional, chiropractor, therapist, nurse, or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you;

(2) “**Document**” **means any writing or record of every type that is in your possession or the possession of your counsel**, including but not limited to written documents, e-mail, cassettes, videotapes, DVDs, photographs, charts, computer discs or tapes, x-rays, drawings, graphs, phono-records, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form. This includes anything provided to you by your healthcare provider(s). You may attach as many sheets of paper as necessary to fully answer these questions. Excluded from this definition are documents that are protected by the attorney-client privilege and/or the work-product doctrine.

**In completing this Fact Sheet you are under oath and must provide information that is true and correct to the best of your knowledge after reasonable inquiry. This Fact Sheet must also be supplemented if additional information or documents become known after completion.**

Information within this Fact Sheet is subject to the Protective Order entered as Case Management Order #8 and will only be used for purposes related to this litigation and/or for purposes of reporting to a regulatory agency to which Defendants are obligated to report plaintiff’s information and such information will not be disclosed otherwise outside this litigation without the plaintiff’s written consent.

1. **CASE INFORMATION**
	1. Name of person completing this form:
	2. Name of the person treated with TRT (if different):
	3. State the following for the civil action that was filed for the above listed individual(s) on whose behalf a claim is being made (“Action”):
		1. Case caption:
		2. Case / Docket Number:
		3. Court in which Action was originally filed:
		4. Contact information for the principal attorney representing you:
			1. Attorney Name:
			2. Email address:
			3. Firm Name and City:
	4. If you are completing this Plaintiff Fact Sheet in a representative capacity (e.g., on behalf of the estate of a deceased person), complete the following (otherwise continue to Section II):
		1. Your name, including other names you have used or by which you have been known and dates you used those names:
		2. Current Address:

In what capacity are you representing the individual or estate:

* + 1. If you were appointed as a representative by a court, then state the following:
			1. Court that appointed you and date of appointment:
			2. What is your relationship to the individual you represent:

**The rest of this Plaintiff Fact Sheet requests information about the person who was treated with TRT. Whether you are completing this Plaintiff Fact Sheet for yourself or for someone else, “you” means the person who was treated with TRT.**

1. **PERSONAL INFORMATION**
	1. Your name (first, middle name or initial, last):
	2. Any other names used or by which you have been known, including alias/nicknames, and dates you used those names:

* 1. Social Security Number:
	2. Date of Birth:
	3. Place of Birth:
	4. Sex: Male \_\_\_\_\_ Female \_\_\_\_\_
	5. Current Address:

Identify each address at which you resided for the last ten (10) years and the approximate dates you resided at each one.

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| --- | --- |
| **Address** | **Approx. Dates of Residence** |
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* 1. Current marital status:
	2. Spouse’s name and date of marriage:
	3. Has your spouse filed a loss of consortium or other claim in connection with this lawsuit? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_ N/A \_\_\_\_\_\_
	4. Name(s) of any former spouse(s), date(s) of marriage, and dates the marriage(s) were terminated, and the nature of the termination (e.g., death, divorce):
	5. If you have children, list each child’s name and date of birth:

|  |  |
| --- | --- |
| **Child’s Name** | **Date of Birth** |
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* 1. Provide the following information about your parents and siblings.

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| --- | --- | --- | --- | --- |
| **Name** | **Relationship to You** | **Age** | **Date of Death (if applicable)** | **Cause of Death (if applicable)** |
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* 1. Identify all schools you attended, starting from and including high school:

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| --- | --- | --- | --- | --- |
| **Name of School** | **City/State** | **Approx. Dates of Attendance** | **Degree Awarded** | **Major or Primary Field** |
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* 1. Are you currently employed? Yes \_\_\_\_\_ No \_\_\_\_\_
		1. If yes, identify your current employer as follows:
			1. Name:
			2. Address:
			3. Dates of employment:
			4. Position(s):
			5. Supervisor(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. Identify all of your employers for the past ten (10) years with name, address and telephone number, your employment dates, your position(s) there, and your reason for leaving:

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| --- | --- | --- | --- | --- |
| **Name of Employer** | **Address.** | **Approx. Dates of Employment** | **Position(s)** | **Reason for Leaving** |
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* 1. Are you asserting a claim for lost earnings or future lost earnings: Yes \_\_\_\_\_ No \_\_\_\_\_
		1. If Yes, please state the total amount of time that you have lost from work as a result of any injuries, illnesses, or disabilities claimed in this Action:
		2. If Yes, please provide your earned annual income for each of the last five (5) years:
			1. Year \_\_\_\_\_ Income $\_\_\_\_\_
			2. Year \_\_\_\_\_ Income $\_\_\_\_\_
			3. Year \_\_\_\_\_ Income $\_\_\_\_\_
			4. Year \_\_\_\_\_ Income $\_\_\_\_\_
			5. Year \_\_\_\_\_ Income $\_\_\_\_\_
	2. Are you claiming any out-of-pocket medical expenses and/or bills, including amounts, as a result of any injuries, illnesses, or disabilities claimed in this Action?
	Yes \_\_\_\_\_ No \_\_\_\_\_
		1. If yes, state the approximate amount of such expenses at this time: $
		2. Have any medical expenses been reimbursed or paid on your behalf?
		Yes \_\_\_\_\_ No \_\_\_\_\_ Unsure \_\_\_\_\_\_
			1. If yes, identify the entity(ies) that provided reimbursement or paid those expenses on your behalf:
	3. Have you ever served in any branch of the military? Yes \_\_\_\_\_ No \_\_\_\_\_\_
		1. If yes, identify the branch and dates of service:
		2. If yes, were you ever discharged for any reason relating to your medical or physical condition? Yes \_\_\_\_\_\_ No \_\_\_\_\_
			1. If yes, state what that condition was:
		3. Have you ever been rejected from military service for any reason relating to your medical or physical condition? Yes \_\_\_\_\_ No \_\_\_\_\_
			1. If yes, state what that condition was:
	4. Have you applied for workers’ compensation, social security, or state or federal disability benefits within the last ten (10) years? Yes \_\_\_\_\_ No \_\_\_\_\_
		1. If yes, then as to each application, separately state:
			1. Date (or year) of application:
			2. Nature of claimed injury/disability:
			3. To what agency(ies) or company(ies) did you submit your application:
	5. Have you filed a lawsuit or asserted a claim for damages for personal injury within the past ten (10) years, other than the present lawsuit? Yes \_\_\_\_\_ No \_\_\_\_\_
		1. If yes, then as to each lawsuit or claim, separately state:
			1. Nature of case or claim:
			2. Court where filed:
			3. Case caption (case name or names of adverse parties):
			4. Case number:
			5. Name of your attorney:
	6. In the last ten (10) years, have you been convicted of or pled guilty to any felony and/or have you been convicted of or pled guilty to any crime that involved an alleged act of dishonesty or providing a false statement? Yes \_\_\_\_\_ No \_\_\_\_\_
		1. If yes, then as to each conviction or guilty plea, separately state:
			1. Charge to which you pled guilty to or were convicted:
			2. Court where the action was pending:
			3. Date of conviction:
1. **HEALTHCARE PROVIDERS OF THE PERSON TREATED WITH TRT (“YOU”)**
	1. Identify each physician or other healthcare provider (other than mental healthcare providers, who are addressed in Section III.E below) who has rendered care and treatment to you any time beginning five (5) years prior to your first treatment with TRT up to the present, including physicians or other healthcare providers for your TRT-related injury(ies) as set-forth in Section VII.A below:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Specialty** | **Address** | **Reason for Visit** | **Approx. Dates/Years of Visits** |
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* 1. Identify each hospital, clinic, or health care facility where you were hospitalized (inpatient, outpatient, or emergency room visit) beginning years five (5) years prior to your first treatment with TRT up to the present:

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| --- | --- | --- | --- |
| **Name** | **Address** | **Approximate Admission Date(s)** | **Reason for Admission** |
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* 1. Identify each pharmacy that has dispensed medication to you beginning five (5) years prior to your first treatment with TRT up to the present:

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| --- | --- | --- | --- |
| **Name** | **Address** | **Name of Medication(s) Dispensed** | **Approx. Dates/Years You Used Pharmacy** |
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* 1. Identify each insurance carrier by whom you were covered by health insurance or any other form of medical coverage at any time beginning five (5) years prior to treatment with TRT up to the present, and include all private insurance and public assistance (such as Medicaid, Medicare, and TriCare) if applicable:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Insurance Company or Public Assistance Program**  | **Policy Number** | **Name of Policyholder / Insured (if different than you)** | **Approx. Dates of Coverage** |
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* 1. Are you asserting a claim for any psychological or psychiatric injury (other than garden variety emotional distress) as a consequence of your use of TRT? Yes \_\_\_\_\_ No \_\_\_\_\_
		1. If yes, identify each psychiatrist, psychologist, or other mental health care provider who you have seen for any psychiatric and/or psychological condition(s) from the five (5) years prior to your treatment with TRT until the present:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Specialty** | **Address** | **Reason for Visit** | **Approx. Dates/Years of Visits** |
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1. **MEDICAL BACKGROUND OF THE PERSON TREATED WITH TRT (“YOU”)**
	1. Current Height:
	2. Current Weight:
	3. Do you currently suffer from any serious physical injuries, illnesses or disabilities other than those that you believe were caused by TRT? Yes \_\_\_\_\_ No \_\_\_\_\_
		1. If yes, provide the information requested below:

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| --- | --- | --- | --- |
| **Injury, Illness or Disability** | **Date of Onset** | **Date of Diagnosis** | **Physician Who Diagnosed You (Name and Address)** |
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* 1. For the period of time fifteen (15) years prior to your use of TRT up to the present, have you ever used tobacco (including cigarettes, cigars, pipes, and/or chewing tobacco/snuff)? Yes \_\_\_\_\_ No \_\_\_\_\_
		1. If yes, provide the information requested for each type of tobacco ever used:

|  |  |  |  |
| --- | --- | --- | --- |
| **Type(s) of tobacco used** | **Dates of Use (approx.)** | **Amount Used Per Day (approx.)** | **Date Use Stopped (Leave Blank if Currently Use)** |
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* 1. For the period of time five (5) years prior to your treatment with TRT up to the present, did you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_
		1. If yes, what was your approximate average alcohol consumption during that time:

\_\_\_\_\_ approximately drinks per day, or

\_\_\_\_\_ approximately drinks per week, or

\_\_\_\_\_ approximately drinks per month, or

\_\_\_\_\_ approximately drinks per year, or

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. For the period of time five (5) years prior to your first treatment with TRT up to the present, did you consume caffeinated beverages? Yes \_\_\_\_\_ No \_\_\_\_\_
		1. If yes, what was your approximate average caffeine consumption during that time:

\_\_\_\_\_ approximately drinks per day, or

\_\_\_\_\_ approximately drinks per week, or

\_\_\_\_\_ approximately drinks per month, or

\_\_\_\_\_ approximately drinks per year, or

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* + 1. Identify the type(s) of caffeinated beverages consumed:
	1. Excluding the injury(ies) that are the subject of your current lawsuit, have you ever been diagnosed with or sought treatment for any of the following conditions?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Condition** | **Yes** | **No** | **Unsure** | **If, Yes, Approx. Date of Onset/ Diagnosis** |
| Aneurysm or Aortic aneurysm |  |  |  |  |
| Angina (stable or unstable) or chest pain |  |  |  |  |
| Any blood clotting disorder |  |  |  |  |
| Abnormal or irregular heart-beat |  |  |  |  |
| Arteriosclerosis (hardening of the arteries) |  |  |  |  |
| Bleeding disorder |  |  |  |  |
| Blood clots or thrombosis |  |  |  |  |
| Cardiovascular disease |  |  |  |  |
| Congenital heart abnormality or condition |  |  |  |  |
| Congestive heart failure or cardiomyopathy |  |  |  |  |
| Coronary artery disease or other heart disease |  |  |  |  |
| Deep Vein Thrombosis (DVT) |  |  |  |  |
| Enlarged heart/cardiomegaly |  |  |  |  |
| Heart attack (or myocardial infarction [MI]); silent MI |  |  |  |  |
| Hypertension or high blood pressure; pre-hypertension |  |  |  |  |
| Pulmonary Embolism (PE) |  |  |  |  |
| Seizure disorder or epilepsy |  |  |  |  |
| Any Stroke: ischemic or hemorrhagic; brain hemorrhage; transient ischemic attack (TIA) |  |  |  |  |
| Venous thromboembolism (VTE) |  |  |  |  |

* 1. If you answered “yes”, to question G, then provide the information requested below:

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| --- | --- | --- | --- |
| **Condition** | **Health Care Provider** | **Treatment Received** | **Approx. Dates or Years of Treatment/Visits** |
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* 1. Are you are claiming that you suffered from a stroke, transient ischemic attacks, blood clots, venous thromboembolism, deep vein thrombosis, or a pulmonary embolism as a result of your treatment with TRT? Yes \_\_\_\_\_ No \_\_\_\_\_
	2. Are you are you claiming that you suffered from a heart attack, myocardial infarction, or any other heart-related condition as a result of your treatment with TRT? Yes \_\_\_\_\_ No \_\_\_\_\_
	3. If you answered “yes”, to questions I or J, then provide the information requested below with regard to all treatment received by you in the last ten (10) years for any of these conditions, regardless of whether the treatment occurred before or after your treatment with TRT:

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **Health Care Provider** | **Treatment Received** | **Approx. Dates or Years of Treatment/Visits** |
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1. **MEDICATIONS OF THE PERSON TREATED WITH TRT (“YOU”)**
	1. Are you currently taking any medications, either by prescription or over-the-counter, including any supplements or herbal remedies ? Yes \_\_\_\_ No \_\_\_\_\_
		1. If yes, provide the information requested below for each medication, supplement or remedy:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Medication** | **Approx. Dates of Use** | **Why Do You Use This Medication?** | **Prescribing Health Care Provider**  | **Pharmacy or Store Where Purchased** |
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* 1. To the best of your recollection are there any prescription medications, other than those identified, in Section V.A., above, that you have taken on a regular basis (meaning taken for approximately 30 consecutive days) for any duration for the five (5) years prior to your first treatment with TRT up to the present. Yes \_\_\_\_\_ No \_\_\_\_\_
		1. If yes, provide the information requested below for each medication, supplement or remedy:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Medication** | **Approx. Dates of Use** | **Why Did You Use This Medication?** | **Prescribing Health Care Provider**  | **Pharmacy or Store Where Purchased** |
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* 1. For the period of one (1) year prior to the onset of injuries for which recovery is sought in this action, have you ever taken/ingested any illegal or illicit drug Yes\_\_\_ No\_\_\_

1. If yes, provide the information requested below:

|  |  |
| --- | --- |
| **Name of Drug** | **Approx. Dates of Use** |
|  |  |
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1. **FAMILY MEDICAL HISTORY OF THE PERSON TREATED WITH TRT (“YOU”)**
	1. Indicate, to the best of your knowledge, whether your biological parents, siblings, or grandparents have ever suffered from any of the following conditions:

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **Yes** | **No** | **Unsure** |
| Aneurysm or Aortic aneurysm |  |  |  |
| Angina (stable or unstable) or chest pain |  |  |  |
| Any blood clotting disorder |  |  |  |
| Abnormal or irregular heart-beat |  |  |  |
| Arteriosclerosis (hardening of the arteries) |  |  |  |
| Bleeding disorder |  |  |  |
| Blood clots or thrombosis |  |  |  |
| Cardiovascular disease |  |  |  |
| Congenital heart abnormality or condition |  |  |  |
| Congestive heart failure or cardiomyopathy |  |  |  |
| Coronary artery disease or other heart disease |  |  |  |
| Deep Vein Thrombosis (DVT) |  |  |  |
| Enlarged heart/cardiomegaly |  |  |  |
| Heart attack (or myocardial infarction [MI]); silent MI |  |  |  |
| Hypertension or high blood pressure; pre-hypertension |  |  |  |
| Pulmonary Embolism (PE) |  |  |  |
| Seizure disorder or epilepsy |  |  |  |
| Any Stroke: ischemic or hemorrhagic; brain hemorrhage; transient ischemic attack (TIA) |  |  |  |
| Venous thromboembolism (VTE) |  |  |  |

* 1. For each condition for which you answered “Yes” in the previous chart, provide the information requested below:

|  |  |
| --- | --- |
| **Condition** | **Relationship to You** |
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1. **TREATMENT WITH TRT**
	1. Identify the total period of time you were treated with TRT:
		1. Were there times when your TRT treatment was discontinued during that period? Yes \_\_\_\_\_ No \_\_\_\_\_ Don’t Recall \_\_\_\_\_
	2. Complete the following chart with respect to each TRT medication to identify each product with which you were treated:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Drug Name** | **Prescribing Physician** | **Pharmacy That Dispensed** | **Approx Dates of Use** | **How Often Administered or Applied** |
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* 1. If you were treated with TRT, but do not presently recall the name of the drug, provide the information requested below:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type: (Patch, Gel, Injection, Tablets, Pellets or Capsules)** | **Dates of Use**  | **Prescribing or Dispensing Health Care Provider** | **Pharmacy or store where purchased**  | **Date(s) of purchase** |
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* 1. Identify any other relevant information to support and/or identify how you obtained your TRT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* 1. If any gaps of time in your usage of any TRT product, please identify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Produce all records or other information that documents that you or someone on your behalf was dispensed prescriptions and/or samples of the TRT products used by you prior to the date of your alleged TRT-related injuries (this information may include, but is not limited to, pharmacy records, prescription records, personal notes, medical records and/or sworn statements from prescribing healthcare provider or any other healthcare providers).
	2. Did you ever receive any samples of TRT? Yes \_\_\_\_\_ No \_\_\_\_\_ Don’t recall \_\_\_\_\_
		1. If yes, identify who gave you the sample, when you received it, the specific products included in the samples, and how many samples you received:
	3. State whether you requested TRT from any Health Care Provider. Yes \_\_\_\_\_ No \_\_\_\_\_
		1. If yes, identify the drug requested:
		2. Identify the reason requested:
		3. Identify the Health Care Provider(s) from whom TRT was requested:
	4. Were you given any written instructions, warnings, or other information regarding the use of TRT (including but not limited to a Package Insert, a Patient Medication Guide, or product brochure)? Yes \_\_\_\_\_ No \_\_\_\_\_ Don’t recall \_\_\_\_\_
		1. If yes, state when the written instructions, warnings, or other information regarding the use of TRT were given and identify each person or entity from whom you received the instructions, warnings or other information.
			1. Approx. date:
			2. Name of person or entity (and address if not otherwise provided):
		2. If yes, produce such written instructions, warnings, or other information regarding the use of TRT, if in Plaintiff’s possession.
	5. Do you have in your possession or does your attorney have any of the actual packaging information that accompanied the actual TRT product with which you allege to have been treated? Yes \_\_\_\_\_ No \_\_\_\_\_
		1. If yes, who currently has custody of the packaging information and/or any remaining medication?
	6. Were you given any oral instructions, warnings, or other information regarding the use of TRT? Yes \_\_\_\_\_ No \_\_\_\_\_ Don’t recall \_\_\_\_\_
		1. If yes, state when the oral instructions, warnings, or other information regarding the use of TRT were given and identify each person or entity from whom you received the instructions, warnings, or other information.
			1. Approx. date:
			2. Name of person or entity (and address and telephone number if not otherwise provided):
	7. What symptoms do you believe you were experiencing before receiving a prescription for TRT?
	8. Were your testosterone levels tested prior to receiving a prescription for TRT?
	Yes \_\_\_\_\_ No \_\_\_\_\_ Don’t recall \_\_\_\_\_
	9. Did you receive a diagnosis of androgen deficiency or hypogonadism prior to receiving a prescription for TRT? Yes \_\_\_\_\_ No \_\_\_\_\_ Don’t recall \_\_\_\_\_
		1. If yes, identify the approx. date you were diagnosed and the Health Care Provider who made the diagnosis:
	10. Were your testosterone levels tested while you took or used TRT?
	Yes \_\_\_\_\_ No \_\_\_\_\_ Don’t recall \_\_\_\_\_
	11. Did you experience any changes or differences in the symptoms you describe above in Question I after being treated with TRT? Yes \_\_\_\_\_ No \_\_\_\_\_ Don’t recall \_\_\_\_\_
		1. If yes, describe those changes or differences:
	12. Have you ever seen, read, or heard any advertisements (e.g., in magazines, television commercials, radio, or web-related advertisements) for TRT?

 Yes \_\_\_\_\_ No \_\_\_\_\_ Don’t recall \_\_\_\_\_

* + 1. If yes, describe each such advertisement, including the name of any TRT product mentioned in the advertisement, the form of the media (e.g. brochure, magazine, TV, radio, website, etc.) of the advertisement, and the dates when you saw, read, or heard the advertisement:
	1. Have you ever seen, read, or heard any advertisements (e.g., in magazines, television commercials, radio or web-related advertisements) relating to low testosterone or hypogonadism? Yes \_\_\_\_\_ No \_\_\_\_\_ Don’t recall \_\_\_\_\_
		1. If yes, identify the advertisement, including the form of media (e.g. brochure, magazine, TV, radio, website, etc.) of the advertisement and the dates when you saw, read, or heard the advertisement:
	2. Have you ever visited any website containing information regarding TRT or the treatment of low testosterone or hypogonadism? Yes \_\_\_\_\_ No \_\_\_\_\_ Don’t recall \_\_\_\_\_
		1. If yes, identify the website, when visited, and describe any information you obtained:
	3. Excluding online questionnaires prepared by your attorneys, have you completed an online questionnaire about TRT or the treatment of low testosterone or hypogonadism? Yes \_\_\_\_\_ No \_\_\_\_\_ Don’t recall \_\_\_\_\_
		1. If yes, identify the questionnaire, when completed, and describe your responses:
	4. Other than through your attorneys, have you or do you believe you have had any communication, oral or written, with any company that makes a TRT product or their representatives (including email, text messages, via the website)?

Yes \_\_\_\_\_ No \_\_\_\_\_ Don’t recall \_\_\_\_\_

* + 1. If yes, provide the information requested below:

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Communication** | **Type of Communication** | **Name of Company and/or Any Representative** | **Substance of Communication** |
|  |  |  |  |
|  |  |  |  |

1. **INJURIES OF THE PERSON TREATED WITH TRT (“YOU”) AND DAMAGES**
	1. Are you claiming any physical injuries, illnesses or disabilities related to your treatment with TRT? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, provide the information requested below:

* + 1. Identify the injuries, illnesses or disabilities that you claim are related to your treatment with TRT and the date on which those injuries occurred.
		2. Are the injuries, illnesses, or disabilities continuing? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, explain:

* + 1. How did you first become aware of your injuries, illnesses or disabilities?
		2. Were there any witnesses when your injuries, illnesses or disabilities occurred? Yes \_\_\_\_\_ No \_\_\_\_\_
			1. If yes, identify his or her name(s), address(es), and his or her relationship to you:
		3. Produce medical records that show your TRT-related injury (e.g., hospital discharge summary).
	1. Were you ever hospitalized for your injuries, illnesses, or disabilities?
	Yes \_\_\_\_\_ No \_\_\_\_\_
		+ 1. If yes, provide the information requested below:

|  |  |  |
| --- | --- | --- |
| **Date of admission (approx.)** | **Date of discharge (approx.)** | **Hospital name(s) and address(es)** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

* 1. Have you had any communications, oral or written, with any doctor or other Health Care Provider (not affiliated with your attorney) about whether the injuries, illnesses or disabilities claimed in this Action are or are not related to your treatment with TRT?
	Yes \_\_\_\_\_ No \_\_\_\_\_ Don’t know \_\_\_\_\_
		1. If “Yes”, please identify the name, address and approximate date of communication with said health care provider:
1. **FACT WITNESSES**
	1. Please identify all persons who you believe possess information concerning your claimed injury(ies) and damages other than your Healthcare Providers and/or Oral Healthcare Providers, and please state their name address and his/her/their relationship to you:

Name:

Address:

Relationship to you:

Name:

Address:

Relationship to you:

Name:

Address:

Relationship to you:

1. **DECEASED PERSONS TREATED WITH TRT**
	1. If you are filling this out on behalf of a deceased person, provide either a copy of the Death Certificate for that person or the following information:
		1. Date of death:
		2. Place of death (city, state and country):
		3. Facility or location where death occurred:
		4. Name of physician who signed death certificate:
		5. Cause of death:
		6. State whether an autopsy was performed, and if so, who performed it (i.e., name of Medical Examiner) and when:
2. **AUTHORIZATIONS**
	1. For each Health Care Provider and/or pharmacy identified anywhere on the Fact Sheet, provide a completed and signed (but undated) Health Care Authorization in the form attached as Exhibit B to Case Management Order No. 9 (“CMO 9”).
	2. If you are eligible for Medicare benefits, provide completed and signed (but undated) authorizations and/or waivers permitting release of documents and information relating to your Medicare coverage and any benefits or payments you have received.
	3. If you answered “yes” to question E in Section III, stating that you are you asserting a claim for any psychological or psychiatric injury (other than garden variety emotional distress) as a consequence of your use of TRT, provide a completed and signed (but undated) Authorization for Release of Mental Health records attached as Exhibit C to CMO 9 for each agency or company you submitted your application to in the last 10 years.
	4. If you answered “yes” to question Q in Section II, and you are asserting a claim for lost earnings or future loss of earnings, then for each Employer identified on the Fact Sheet, provide a completed and signed Employment Authorization attached as Exhibit D to CMO 9 for each employer.
	5. If you answered “yes” to question T in Section II, stating that you applied for workers’ compensation in the past ten (10) years, provide completed and signed (but undated) authorizations and/or waivers permitting release of documents and information from each agency or company you submitted your application to in the last 10 years.
	6. If you answered “yes” to question T in Section II, stating that you applied for disability in the past ten (10) years, provide completed and signed (but undated) authorizations and/or waivers permitting release of documents and information from each agency or company you submitted your application to in the last 10 years.
	7. For each insurer listed in response to question D in Section III, provide completed and signed (but undated) authorizations and/or waivers permitting release of documents and information from said insurer(s).
3. **DOCUMENT REQUESTS**

By responding Yes or No, identify if you have any of the following documents in your custody or possession, including in hard copy or in electronic form (You need NOT obtain records from in response to this obligation to produce documents, rather this only requests documents in your custody or possession)). Nothing in any of the document requests herein shall be interpreted to seek the production of materials that are protected by the attorney-client privilege or the work product doctrine.

For any documents you have (and have thus indicated so, by checking “Yes), attach a copy of those documents to this Plaintiff Fact Sheet:

1. All non-privileged documents you reviewed that assisted you in the preparation of your answers to this Plaintiff Fact Sheet. Yes \_\_\_\_\_ No \_\_\_\_\_
2. A copy of all medical records and/or documents in currently in your possession related to your treatment with TRT. Yes \_\_\_\_\_ No \_\_\_\_\_
3. A copy of all medical records and/or documents from any hospital or Health Care Provider who treated you from a period of five(5) years prior to your first treatment with TRT to date who treated you for any disease, condition, or symptom referred to in any of your answers to the questions above and concerning any condition or injury you claim is related to being treated with TRT, including but not limited to all tests or imaging studies of any part of your body that relate in any manner to the diagnosis, treatment, care or management of your condition and the injuries alleged in the Action. Yes \_\_\_\_\_ No \_\_\_\_\_
4. If you have been the claimant or subject of any workers’ compensation, social security or other disability proceeding, all documents currently in your possession related to such proceeding. Yes \_\_\_\_\_ No \_\_\_\_\_
5. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, pharmacy handouts or other materials distributed with or provided to you in connection with your treatment with TRT. Yes \_\_\_\_\_ No \_\_\_\_\_
6. Copies of all advertisements or promotions or brochures for TRT you claim to have seen before or during your TRT treatment. Yes \_\_\_\_\_ No \_\_\_\_\_
7. Copies of all articles discussing TRT you claim to have seen before or during your TRT treatment. Yes \_\_\_\_\_ No \_\_\_\_\_
8. Copies of the entire packaging, including the box and label for TRT (plaintiffs or counsel must maintain the originals of the items requested in this subpart). Yes \_\_\_\_\_ No \_\_\_\_\_
9. All documents relating to your purchase of TRT, including but not limited to, receipts, prescriptions, pharmacy records, prescription records, containers, labels, or records of purchase. Yes \_\_\_\_\_ No \_\_\_\_\_
10. All documents known to you and in your custody or possession which mention TRT or any alleged health risks related to TRT in your possession at or before the time of the injury(ies) alleged in the Action, other than legal documents, documents provided by your attorney, or documents obtained or created for the purpose of seeking legal advice or assistance. Yes \_\_\_\_\_ No \_\_\_\_\_
11. All documents constituting any communications or correspondence between you and any representative of any company that makes a TRT product. Yes \_\_\_ No \_\_\_
12. All documents you (and not your attorney)obtained from any source relating to TRT or to the alleged effects of using TRT. Yes \_\_\_\_\_ No \_\_\_\_\_
13. All documents you (and not your attorney) obtained from any source relating to low testosterone or hypogonadism. Yes \_\_\_\_\_ No \_\_\_\_\_
14. If you are making a for claim loss of earnings or earnings capacity, your W-2s for each of the last five years. Yes \_\_\_\_\_ No \_\_\_\_\_
15. If you are making a claim for loss of earnings or earnings capacity all employment records relating to being treated with TRT or to your alleged injuries, illnesses, or disabilities. Yes \_\_\_\_\_ No \_\_\_\_\_
16. If you claim loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other Health Care Provider. Yes \_\_\_\_\_ No \_\_\_\_\_
17. All insurance, Medicare/Medicaid/other public programs, and social security records relating to being treated with TRT or to your alleged injuries, illnesses, or disabilities. Yes \_\_\_\_\_ No \_\_\_\_\_
18. Copies of letters of testamentary or letters of administration relating to your status as plaintiff (if applicable). Yes \_\_\_\_\_ No \_\_\_\_\_
19. Copy of decedent’s death certificate and autopsy report (if applicable). Yes \_\_ No \_\_\_\_\_
20. **DECLARATION**

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that all of the information provided and in connection with this Plaintiff Fact Sheet is true and correct to the best of my knowledge information and belief at the present time.

Further, I acknowledge that I have an obligation to supplement the above responses if I become aware of additional responsive information, or if I learn that they are in some material respects incomplete or incorrect:

Date:

 Signature

 Print Name