BAYCOL

MASTER FILE NO. 0247408

	§	IN THE DISTRICT COURT OF
	§	
IN RE: TEXAS SECOND REGION	§	HARRIS COUNTY, TEXAS
BAYCOL LITIGATION	§	
	§	295TH JUDICIAL DISTRICT

PLAINTIFF'S FACT SHEET

Each Plaintiff who used Baycol must complete this Fact Sheet. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You may and should consult with your attorney if you have any questions regarding the completion of this form.

If you are completing the form for someone who has died or who cannot complete the Fact Sheet him/herself, please answer as completely as you can for that person. You may attach as many sheets of paper as necessary to answer these questions.

I. Case Information

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

1. Case caption: _____

2. Civil Action No: _____

3. Court in which action was originally filed: _____

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

_____
Name

_____
Firm

_____

Street Address

City, State and Zip Code

Telephone Number

Fax Number

E-mail address

B. If you are completing this Fact Sheet in a representative capacity (on behalf of the estate of a deceased person or a minor), please state:

1. Your name: _____
2. Address: _____
3. In what capacity are you representing the person? _____
4. If a court appointed you to act on behalf of the estate of the deceased person or minor, state the court and date of appointment: _____
5. Your relationship to deceased or represented person: _____
6. If you represent a decedent's estate, state the date of decedent's death: _____

The remainder of this Fact Sheet requests information about the person who used the Baycol. If you are completing this Fact Sheet for someone else, please assume that "you" means the person who used Baycol.

II. Personal Information

A. Name: _____

B. Have you ever used any other names and, if so, when: _____

C. Current and Former Addresses (Last 10 Years):

_____

_____

D. Driver's License & Social Security Number:

_____

E. Date and place of birth:

_____

F. Sex: Male _____ Female _____

G. Height: _____ Weight: _____

III. <u>Baycol Use</u>

A. Have you ever taken Baycol? Yes _____ No _____

If "yes," then complete the following:

Dates of use	**Dosage**	**How obtained? (Prescription, Sample, Other) (name and address)**	**Dispensing pharmacy (name and address)**

B. Were you given any instructions, warnings or other information (oral or written) regarding Baycol?

_____ Yes _____ No _____ I don't know _____ I don't remember

1. If "yes," when did you receive the information? _____
2. Who gave you the instructions, warnings or information? _____
3. Were the warnings, instructions or information oral or written? _____
4. If you no longer have the written information in your possession, or the information was oral, to the best of your ability, please describe the instructions,

warnings or
information that you received. _____

_____

C. Please list any prescription or over-the-counter drug, any dietary supplement, vitamin, or herbal remedy that you were taking at the same time you were taking Baycol.

Name of Drug	Date(s) Taken	Prescribing Doctor	Name and Address of Pharmacy Where Obtained

IV. Medical History and Health Care Providers

A. Please provide the following information for each doctor, clinic, hospital, or healthcare provider that you have seen or who has treated you during the last ten (10) years. If you cannot recall all of the details regarding the healthcare providers that you have seen, please provide as much information as you can.

1. Name of doctor or clinic: _____
   Specialty, if any: _____
   Address: _____
   Phone: _____
2. Name of doctor or clinic: _____
   Specialty, if any: _____
   Address: _____
   Phone: _____
3. Name of doctor or clinic: _____
   Specialty, if any: _____
   Address: _____
   Phone: _____
4. Name of doctor or clinic: _____
   Specialty, if any: _____
   Address: _____
   Phone: _____
5. Name of doctor or clinic: _____
   Specialty, if any: _____
   Address: _____
   Phone: _____

B. [ATTACH ADDITIONAL PAGES, IF NECESSARY] Have you had any of the following tests or procedures in the past ten (10) years?

Test/Procedure	Yes	No	I don't know
Creatine kinase (CK)/ Creatine phosphokinase (CPK)			
EMG/Nerve conduction Studies			
Cystoscopy			
Liver biopsy			
Other diagnostic tests) or imaging of the kidney, liver or muscles			

C. Have you been tested or diagnosed for any of the following in the last ten (10) years:

Condition	Tested Date	Diagnosed Date	I don't know
Diabetes			
Atherosclemsis			
Myocardial infarction/heart attack			
Abnormal heart rhythm			
Congestive heart failure			
Angina			
Thyroid disorder			
Auto-immune disease			
High cholesterol			
Elevated trigylcerides			
Hypertension/high blood pressure			
Obesity			
Thyroid disorder			
Autoimmune disease			
Abnormal heart rhythm			
Congestive heart failure			
Angina			
Myocardial infarction			
Atherosclerosis			

D. Have you taken any of the following medications during the past ten (10) years? If you cannot recall all of the details requested, please provide as much information as you can.

Drug	Yes	No	I don't know	Still Use	If yes, date(s) taken and prescribing doctor	Name, date, and address of pharmacy where obtained
CHOLESTEROL LOWERING DRUGS						
Lescol [Fluvastatin]						
Lipitor [Atorvastatin]						
Mevacor [Lovastatin]						
Pravachol [Pravastatin]						
Zocor [Simvastatin]						
Niacin [Vitamin B3]						
LoCholest [Cholestyramine]						
Questran [Cholestyramine]						
Prevalite [Cholestyramine]						
TRIGLYCERIDE-LOWERING DRUGS						
Lopid						
Gemfibrozil						
Tricor [Febofibrate]						
Bezafibrate						
Ciprofibrate						
ANTI-INFECTIVE DRUGS						
Diflucan [Fluconazole]						
Erythrocin & Others [Erythromycin]						
Flagyl [Metronidazole]						
Nizoral [Ketoconazole]						
Sporanox [Itraconazole]						
IMMUNO-SUPPRESSIVE DRUGS						
Neoral [Cyclosporine]						
Sandimmune [Cyclosporine]						
OTHER						
Anticoagulants						
Heart Drugs						
Thyroid Medications						
Other						

V. Physical Injuries, Illness and Damages Related to Baycol

A. If you are making a claim for physical injuries or illness from taking Baycol, please describe the following:

1. Nature of physical injuries or illness: _____

_____

2. The date that you first became aware of the physical injuries or illness: _____

_____

1. When you were diagnosed with the injuries or illness, and who diagnosed you: _____

_____

1.2. How you first became aware of the physical injuries or illness: _____

_____

5. Are the injuries or illnesses continuing? If so, please describe: _____

_____

_____

Did you see a doctor, clinic or other healthcare provider for the physical injuries or illness listed above?

_____Yes _____No _____I don't know

If "yes," please complete the following for each healthcare provider:

a. Name: _____

b. Address: _____

c. Date of first consultation with that healthcare provider: _____

d. Date of last consultation: _____

e. Do you plan to continue to consult with that healthcare Provider in the future? ____ Yes ____ No

f. Did you discuss whether Baycol contributed to your injury or illness? _____

B. If you are making claims for out-of-pocket expenses as a result of taking Baycol, please complete the following:

1. For what? _____

2. Amount of fees or expenses requesting and incurred: _____

3. Person or company paid or to be paid: _____

A. Are you making a claim for lost wages or lost earning capacity? Yes ____ No ____

For the past 10 years, please identify the following employment related information:

1. Name: _____
Address: _____
Job Duties: _____
Job Title (if known): _____
Dates Employed: _____
Full-time or Part-time (if known): _____
Name of Supervisor (if known _____

2. Name: _____
Address: _____
Job Duties: _____
Job Title (if known): _____
Dates Employed: _____
Full-time or Part-time (if known): _____
Name of Supervisor (if known _____

[ATTACH ADDITIONAL PAGES, IF NECESSARY]

B. Has any insurance or other company provided medical coverage to you or paid medical bills on your behalf related to Baycol?

_____Yes _____No

If "yes," please complete the following:

Name of Company	Address

C. If you are making a specific and distinct claim for emotional distress or psychological injuries (other than a typical claim for mental anguish), please complete the Supplemental Fact Sheet for Claims of Emotional Distress and Psychological Injuries and Harm. The Supplemental Fact Sheet must be completed if you intend to assert a claim for or offer evidence of mental health care and treatment attributable to your use of Baycol.

VI. Documents

Please provide a copy of all of your documents and things which fall into the categories listed below. This includes documents and things in your personal possession, as well as items being held for you by another person, including your lawyer or any relative.

1. A copy of all medical records currently in your possession (excluding psychiatric or psychological records) from any physician, hospital, clinic, healthcare provider or pharmacy that treated you, or filled your prescriptions, in the last ten (10) years.

2. Copies of the entire packaging, including the bottle, box and label, for the Baycol you allege caused you injury. Also include any remaining medication.

3. Copies of letters testamentary or letters of administration relating to your status as plaintiff.

4. Decedent's death certificate (if applicable).

5. A copy of all records evidencing any health insurance coverage of the claim within the last five (5) years including, but not limited to, any coverage with PacifiCare of Texas, Inc., Secured Horizons, or any other HMO or Medicare plus choice organization.

VII. Authorizations

Complete and sign the attached Authorization for Release of Medical Records and attached Authorization for Release of Employment and Unemployment Records.

If you have filed a Workers' Compensation or Social Security disability claim, please complete and sign the attached Authorization for Release of Workers' Compensation and Social Security Records.

VIII. Declaration

I declare under penalty of perjury that all of the information provided in this Plaintiff's Fact Sheet is true and correct to the best of my knowledge, information

and belief, that I have supplied all the documents requested in Part IX of this Plaintiff's Fact Sheet, as required above.

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

Dated	Signature