IN RE: BAYCOL LITIGATION
MDL No. 1431

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 Address: _____

D. How long have you been living at this address? _____

E. List any prior addresses during the last ten (10) years and the dates when you lived at those addresses. If you cannot recall all of the details regarding those addresses, please provide as much information as you can. _____

F. Social Security Number: _____

G. Date and place of birth: _____

H. Sex: Male____ Female_____

I. Marital Status: _____

J. If applicable, name of current spouse and date of marriage: _____

K. If applicable, name of former spouse(s) and date(s) of marriage within the last ten (10) years:_____

L. Name(s) of children and date(s) of birth, if applicable:_____

M. Current employer:

Name:_____
Address:_____
Job Duties:_____
Job Title:_____
Dates Employed:_____
Full-time or Part-time:_____
Name of Supervisor:_____

Are you making a claim for lost wages or lost earning capacity? _____ Yes _____ No

N. Please complete the following information regarding any employers (other than your current employer) that you have had in the last ten (10) years:

1. Name:_____
Address:_____
Job Duties:_____
Job Title:_____
Dates Employed:_____
Full-time or Part-time:_____
Reason for Leaving:_____
Name of Supervisor:_____

2. Name:_____
Address:_____
Job Duties:_____
Job Title:_____
Dates Employed:_____
Full-time or Part-time:_____
Reason for Leaving:_____
Name of Supervisor:_____

O. Please provide the following information about your education:

1. High School

Name:_____
Address:_____
Grade completed:_____
Year graduated:_____

2. Did you attend school beyond high school? _____ Yes _____ No

If "yes," please complete the following for each school that you attended after high school:

Name of School	**Address**	**Dates of Attendance**	**Degree Awarded**	**Major or primary field**

P. Have you used a computer at any time during the past five (5) years?
_____ Yes _____ No

If "yes," please complete the following:

1. Did you have e-mail? _____ Yes _____ No

2. Did you have internet access? _____ Yes _____ No

3. Have you ever visited any website containing information regarding Baycol, statins or the treatment of high cholesterol or high triglycerides?

_____ Yes _____ No _____ I don't know

4. Have you ever visited any chat rooms where Baycol, statins, or the treatment of high cholesterol or high triglycerides was discussed?

_____ Yes _____ No _____ I don't know

5. Have you ever communicated via e-mail or chat room about Baycol, statins or the treatment of high cholesterol or high triglycerides?

_____ Yes _____ No _____ I don't know

Q. Has any insurance or other company provided medical coverage to you or paid medical bills on your behalf in the ten (10) years before you took Baycol through the present?

_____ Yes _____ No

If "yes, please complete the following:

Name of Company	**Address**

R. Have you applied for worker's compensation, social security, or state or federal disability benefits in the past ten (10) years?

_____ Yes _____ No

If "yes," please complete the following for each application. If you cannot recall all of the details regarding such application(s), please provide as much information as you can.

1. Date (or year) of application: _____
2. Type of benefits: _____
3. Amount awarded: _____
4. Basis of your claim: _____
5. If denied, reason for denial: _____
6. To what agency or company you submitted your application (*e.g.*, Pennsylvania Division of Social Security): _____

S. Were you ever rejected or discharged from military service for any reason relating to your health or physical condition?

_____ Yes _____ No

If "yes," then state the reason for the health-related rejection or discharge and when this happened.

_____

_____

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

_____ Yes _____ No

If "yes," please state the court in which the lawsuit was brought and the civil action or docket number assigned to each such claim, action, or lawsuit. If you cannot recall all of the details, please provide as much information as you can.

_____

_____

III. Your Health Care Providers

A. Please provide the following information for each doctor, clinic 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:_____
Specialty, if any:_____
Address:_____
Phone:_____
Reason(s) for visit(s):_____
_____
Medications prescribed or recommended:_____
_____

2. Name:_____
Specialty, if any:_____
Address:_____
Phone:_____
Reason(s) for visit(s):_____
_____
Medications prescribed or recommended:_____
_____

3. Name:_____
Specialty, if any:_____
Address:_____
Phone:_____
Reason(s) for visit(s):_____
_____
Medications prescribed or recommended:_____
_____

4. Name:_____
Specialty, if any:_____
Address:_____
Phone:_____
Reason(s) for visit(s):_____
_____
Medications prescribed or recommended:_____
_____

5. Name:_____
Specialty, if any:_____
Address:_____
Phone:_____
Reason(s) for visit(s):_____
_____
Medications prescribed or recommended:_____
_____

6. Name:_____
Specialty, if any:_____
Address:_____
Phone:_____
Reason(s) for visit(s):_____
_____
Medications prescribed or recommended:_____
_____

7. Name:_____
Specialty, if any:_____
Address:_____
Phone:_____
Reason(s) for visit(s):_____
_____
Medications prescribed or recommended:_____
_____

[ATTACH ADDITIONAL PAGES, IF NECESSARY]

IV. Your Medical Background

A. Height:_____

B. Current Weight:_____

C. Your Smoking History

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

4. Have you ever used any other form of tobacco (snuff, dipping, cigars)?

_____ Yes _____ No _____ I don't know

If "yes," please identify:

a. What form:_____
b. Dates of use:_____
c. Amount of use:_____

D. Alcohol Consumption

On average, how much alcohol do you drink?

_____ None
_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 10 or more drinks per week

E. Please provide the following information for each hospitalization that you have had during the last ten (10) years. If you cannot remember all of the details, please list as much information as you can.

1. Name of hospital:_____
Address:_____
Phone:_____
Reason(s) for hospitalization(s):_____
_____
_____

2. Name of hospital:_____
Address:_____
Phone:_____
Reason(s) for hospitalization(s):_____
_____
_____

3. Name of hospital:_____
Address:_____
Phone:_____
Reason(s) for hospitalization(s):_____
_____
_____

[ATTACH ADDITIONAL PAGES, IF NECESSARY]

F. Please complete the following information for each surgery that you had in the last ten (10) years. If you cannot remember all of the details, please list as much information as you can.

1. Name of operation:_____
   Name of surgeon:_____
   Address of surgeon:_____
   Reason for surgery:_____

2. Name of operation:_____
   Name of surgeon:_____
   Address of surgeon:_____
   Reason for surgery:_____

3. Name of operation:_____
   Name of surgeon:_____
   Address of surgeon:_____
   Reason for surgery:_____

[ATTACH ADDITIONAL PAGES, IF NECESSARY]

G. If you have ever consulted a doctor, clinic or other healthcare provider concerning any kidney condition, illness or disease including kidney failure, polynephritis, nephrosclerosis, kidney stones, proteinuria or hematuria (blood in the urine), please complete the following. If you cannot remember all of the details, please list as much information as you can.

Name of doctor or facility:_____
Address:_____
Date:_____
Diagnosis:_____
Treatment:_____
Medications:_____
Did condition resolve?_____
Current status of condition:_____

H. If you have ever consulted a doctor, clinic or other healthcare provider concerning any liver condition, illness or disease including but not limited to hepatitis, cirrhosis or fatty liver, please complete the following. If you cannot remember all of the details, please list as much information as you can.

Name of doctor or facility:_____
Address:_____
Date:_____
Diagnosis:_____
Treatment:_____
Medications:_____
Did condition resolve?_____

Current status of condition: _____

I. If you have ever consulted a doctor, clinic or other healthcare provider about any musculoskeletal condition or disease including muscle pain or weakness, extreme fatigue, myopathy, polymyositis, fibromyalgia, arthritis, tendonitis, or other muscle related concerns or problems, please complete the following. If you cannot remember all of the details, please list as much information as you can.

Name of doctor or facility: _____
Address: _____
Date: _____
Diagnosis: _____
Treatment: _____
Medications: _____
Did condition resolve? _____
Current status of condition: _____

J. 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 test(s) or imaging of the kidneys, liver or muscles			

If "yes," please complete the following. If you cannot remember all of the details, please list as much information as you can.

a. Type of test: _____
b. Date administered: _____
c. Reason for test: _____
d. Facility name and address: _____
e. Ordering doctor: _____
f. Results/diagnosis: _____
g. Treatment: _____

[ATTACH ADDITIONAL PAGES, IF NECESSARY]

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

Condition	**Yes**	**No**	**I don't know**
Diabetes			
Atherosclerosis			

Condition	Yes	No	I don't know
Myocardial infarction/ heart attack			
Abnormal heart rhythm			
Congestive heart failure			
Angina			
Thyroid disorder			
Autoimmune disease			

If you responded "yes" to any of the above, complete the following information for each condition. If you cannot remember all of the details, please list as much information as you can.

a. Type of condition and date of testing: _____
Testing doctor: _____
Treatment: _____

b. Type of condition and date of testing: _____
Testing doctor: _____
Treatment: _____

c. Type of condition and date of testing: _____
Testing doctor: _____
Treatment: _____

L. Have you ever been diagnosed as having:

Condition	Yes	No	I don't know
High cholesterol			
Elevated trigylcerides			
Hypertension/high blood pressure			
Obesity			
Diabetes			
Thyroid disorder			
Autoimmune disease			
Abnormal heart rhythm			
Congestive heart failure			
Angina			
Myocardial infarction			
Atherosclerosis			

If you responded "yes" to any of the above, please complete the following information for each condition. If you cannot remember all of the details, please list as much information as you can.

a. Condition and date of diagnosis:_____
Name of diagnosing doctor:_____
Treatment:_____

b. Condition and date of diagnosis:_____
Diagnosing doctor:_____
Treatment:_____

c. Condition and date of diagnosis:_____
Diagnosing doctor:_____
Treatment:_____

V. Baycol

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

If "yes," then complete the following:

Dates of use	Dosage	Prescribed by (name and address)	Dispensing pharmacy (name and address)

B. Were you given any **written** instructions, warnings or other information regarding your use of Baycol?

_____ Yes _____ No _____ I don't know

1. If "yes," when did you receive the information?_____

2. Who gave you the information?_____

3. If you no longer have the written information in your possession, please describe the written information that you received to the best of your ability._____
_____
_____

C. Were you ever given any **oral** instructions, warnings or other information regarding your use of Baycol?

_____ Yes _____ No _____ I don't know

1. If "yes," when did you receive them?_____

2. Who gave them to you?_____

3. Please describe the oral instructions you received to the best of your ability._____
_____
_____

D. 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**

VI. Physical Injuries, Illness and Damages

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:_____
_____

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

4. Whether those injuries or illnesses are continuing:_____
_____
_____

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? ____Yes ___No

B. Have you had any discussions with any doctor or other healthcare provider about whether Baycol contributed to your physical injuries or illness?

_____ Yes _____ No

If "yes," provide the doctor's or healthcare provider's name and address, and the date of that discussion. _____
_____
_____

C. 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:_____

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

D. If you are making a claim for emotional distress or psychological injuries, please complete the Supplemental Fact Sheet for Claims of Emotional Distress and Psychological Injuries and Harm.

E. Are there persons (other than those already identified in this Fact Sheet) whom you believe are witnesses to your claimed injuries or damages? If yes, please provide their name(s) and address(es):

1. _____
2. _____
3. _____
4. _____
5. _____

VII. Other Medications

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	If yes, date(s) taken and prescribing doctor	Name 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 [Femofibrate]					
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					

VIII. Family History

A. To the best of your knowledge have any of your children, parents, grandparents or siblings had diabetes, any type of kidney or liver disease, or any type of muscle disorder?

_____ Yes _____ No _____ I don't know

B. If "yes," please complete the following:

Relative's name:_____
Relationship to you:_____
Type of health problem:_____
Date and cause of death, if applicable:_____

Relative's name:_____
Relationship to you:_____
Type of health problem:_____
Date and cause of death, if applicable:_____

Relative's name:_____
Relationship to you:_____
Type of health problem:_____
Date and cause of death, if applicable:_____

Relative's name:_____
Relationship to you:_____
Type of health problem:_____
Date and cause of death, if applicable:_____

IX. 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 (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. 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.

3. All instructions, product warnings, package inserts, advertising materials, pamphlets, magazine or newspaper articles, internet information, promotional materials, any documents or materials from defendants, or pharmacy handouts that you have regarding Baycol.

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

5. If you are claiming lost wages or a loss of earning capacity, your federal tax returns for each of the last five (5) years.

6. If you claim any loss from medical expenses, copies of all bills for which you are seeking reimbursement from any physician, hospital, pharmacy or other health care provider.

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

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

9. All documents of any kind related to other drugs that you took at the same time you were taking Baycol.

X. Authorizations

Complete and sign the attached Authorization for Release of Medical Records (No Psychological Injuries Claimed), and attached Authorization for Release of Employment and Unemployment Records (No Psychological Injuries Claimed).

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.

XI. 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

IN RE: BAYCOL LITIGATION
MDL No. 1431

SUPPLEMENTAL FACT SHEET FOR CLAIMS OF
EMOTIONAL DISTRESS AND PSYCHOLOGICAL INJURIES AND HARM

I. Are you making a claim for mental, emotional, psychological or psychiatric injuries or illness from your use of Baycol? ____ Yes ____ No

II. If you are making a claim for mental, emotional, psychological or psychiatric injuries or illness from your use of Baycol, please provide the following information:

1. Nature of the injury or illness:_____
_____

2. The date you first became aware of this injury or illness:_____
_____

3. How you first became aware of this injury or illness:_____
_____

4. Whether (and if so, how) this injury or illness has changed over time:_____
_____
_____

III. If you have seen a doctor, clinic or any other healthcare provider for treatment of this mental, emotional, psychological or psychiatric injury or illness, please provide the following information:

1. Name:_____
2. Address:_____
3. Date of first consultation with that healthcare provider:_____
4. Date of last consultation:_____
5. Do you plan to continue to consult with that healthcare provider? ____Yes ___No

IV. Have you had any discussions with any doctor or other healthcare provider about whether Baycol contributed to your physical injuries or illness?

_____ Yes _____ No

If "yes," provide the doctor's or healthcare provider's name and address, and the date of that discussion._____
_____
_____

V. If you have experienced or have been treated for any mental, emotional, psychological, or psychiatric condition or problem (including depression) prior to your use of Baycol, please complete the following:

Condition or problem for which treated	Dates of treatment	Treatment provider (name and address)

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 psychiatric or psychological medical records from any physician, hospital, clinic, healthcare provider that treated you in the last ten (10) years.

VII. Authorization

Complete and sign the attached Authorization for Release of Medical Records (Psychological Injuries Claimed), and attached Authorization for Release of Employment and Unemployment Records (Psychological Injuries Claimed).

VIII. Declaration

I declare under penalty of perjury that all of the information provided in this Plaintiff's Supplement 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 VI of this Plaintiff's Supplemental 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