**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF NEW JERSEY**

| | |
|---|---|
| **IN RE: VALSARTAN PRODUCTS LIABILITY LITIGATION**<br><br>**This Document Relates to:** | MDL No. 2875<br><br>Honorable Robert B. Kugler, District Judge<br><br>Honorable Joel Schneider, Magistrate Judge |

# MEDICAL MONITORING CLASS PLAINTIFF'S FACT SHEET

This Fact Sheet must be completed by each plaintiff who has filed a lawsuit related to the use of Valsartan products by the plaintiff. Please answer every question to the best of your knowledge. 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 must supplement your responses if you learn that they are incomplete or incorrect in any material respect. For each question, where the space provided does not allow for a complete answer, please attach additional sheets so that all answers are complete. When attaching additional sheets, clearly label to what question your answer pertains to. Please do not leave any blank spaces; if a question does not apply, respond "N/A".

In filling out this form, please use the following definitions: (1) the terms "Plaintiff," "you," and "your," refer to the individual referenced in the caption of this Plaintiff's Fact Sheet, (2) **"health care provider"** means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, provider of telemedical services, whether real-time telemedicine, remote patient monitoring, or store-and-forward service, or other facility that provides medical, dietary, psychiatric, or psychological care or advice, and any pharmacy, weight loss center, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care, and/or treatment of the plaintiff or plaintiff's decedent; (3) **"document"** means any writing or record of every type that is in your possession, including but not limited to written documents, documents in electronic format, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phone- 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; (4) "Valsartan product" means any Valsartan containing product, including but not limited to Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCZT); (5) "Complaint" means the operative complaint filed in your case, whether an original or amended or subsequent complaint.

Information provided by plaintiff will only be used for purposes related to this litigation. This Fact Sheet is completed pursuant to the Federal Rules of Civil Procedure governing discovery (or, for state court cases, the governing rules of the state in which the case is pending) and Case Management Order No. 7 ("CMO-7").

## I. CORE CASE INFORMATION

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

| | |
|---|---|
| Caption: | |
| Court and Docket No. (and MDL Docket No. if different): | Court:<br>Docket No.: |
| Plaintiff's Attorney, Law Firm, Address, Phone Number, and Email Address: | Attorney:<br>Law Firm:<br>Address:<br>Phone Number:<br>Email Address: |
| Date Lawsuit Filed: | |
| Jurisdiction where suit would have been filed (if direct filed into MDL): | |

B. Please provide the following information for the Plaintiff/decedent on whose behalf this action was filed, and for any spouse of the plaintiff:

| | | | |
|---|---|---|---|
| First Name: | | Last Name: | |
| Address: | | City: | |
| State: | | Zip Code: | |
| Date of Birth: | | Gender: | |
| Social Security Number: (including past SSNs, if applicable): | | All other names by which Plaintiff has been known (including, but not limited to maiden, prior married, nicknames, and aliases): | |

Primary Language if other than English: _____

C. Please provide the following information regarding usage of Valsartan products.

**I HAVE IN MY POSSESSION RECORDS DEMONSTRATING USE OF VALSARTAN, AMLODIPINE/VALSARTAN, VALSARTAN/HYDROCHLOROTHIAZIDE (HCTZ), AND/OR AMLODIPINE/VALSARTAN/HYDROCHLOROTHIAZIDE (HCTZ): Yes ☐ No ☐**

**IF YES, YOU MUST ATTACH COPIES OF PRESCRIPTION AND/OR PHARMACY RECORDS DEMONSTRATING PRODUCT USE. ALSO ATTACH ANY COPIES OR PHOTOGRAPHS OF PRESCRIPTION BOTTLES OR LABELING IN YOUR POSSESSION.**

**Identify Product(s) and set forth for each:**

| | | | |
|---|---|---|---|
| **Select Product:** | | | |
| **Dosage:** | | | |
| **NDC Code (if known):** | | | |
| **Lot Number (if known):** | | | |
| **Batch Number (if known):** | | | |
| **API Manufacturer (if known):** | | | |
| **Labeler/Distributor (if known):** | | | |
| **Repackager (if known):** | | | |
| **Start Date:** | | | |
| **End Date:** | | | |
| **Reason for Prescription:** | | | |
| **Name and Address of Prescribing Physician:** | | | |
| **Name and Address of Pharmacy(ies):** | | | |
| **Check if you have records demonstrating Product ID** | ☐ | ☐ | ☐ |

| | | | |
|---|---|---|---|
| **Select Product:** | | | |
| **Dosage:** | | | |
| **NDC Code (if known):** | | | |
| **Lot Number (if known):** | | | |
| **Batch Number (if known):** | | | |
| **API Manufacturer (if known):** | | | |
| **Labeler/Distributor (if known):** | | | |
| **Repackager (if known):** | | | |
| **Start Date:** | | | |
| **End Date:** | | | |
| **Reason for Prescription:** | | | |
| **Name and Address of Prescribing Physician:** | | | |
| **Name and Address of Pharmacy(ies):** | | | |
| **Check if you have records demonstrating Product ID** | ☐ | ☐ | ☐ |

| | | | |
|---|---|---|---|
| **Select Product:** | | | |
| **Dosage:** | | | |
| **NDC Code (if known):** | | | |
| **Lot Number (if known):** | | | |
| **Batch Number (if known):** | | | |
| **API Manufacturer (if known):** | | | |
| **Labeler/Distributor (if known):** | | | |
| **Repackager (if known):** | | | |
| **Start Date:** | | | |
| **End Date:** | | | |
| **Reason for Prescription:** | | | |
| **Name and Address of Prescribing Physician:** | | | |
| **Name and Address of Pharmacy(ies):** | | | |
| **Check if you have records demonstrating Product ID** | ☐ | ☐ | ☐ |

**IF YOU DID NOT CHECK THE BOX INDICATING YOU HAVE RECORDS DEMONSTRATING PRODUCT ID FOR ANY OF THE DRUGS LISTED ABOVE, YOU MUST CERTIFY AS FOLLOWS (check <u>all</u> that apply):**

**I certify that I have made reasonable, good faith efforts to identify the manufacturer of the Valsartan product(s) used in my treatment: ☐**

***If certifying the above, please describe your reasonable, good faith efforts:***

**I certify that I have requested records from:**

**Pharmacy, ☐**

**Prescribing physician, ☐ and/or**

**Health insurance provider; ☐**

**and the manufacturer either remains unknown at this time ☐**

**or I am awaiting the records. ☐**

## II. PERSONAL INFORMATION

A. Background Information

1. Medicare Health Insurance Claim Number (if applicable): _____

2. Name: _____

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

4. Current address and date when you began living at this address:

   Address: _____

   Date: _____

5. Identify each address at which you have resided during the last ten (10) years and the approximate dates during which you lived at each address (most recent first):

| Address | Approximate Dates you lived at each address |
|---|---|
| | to ☐ Present |
| | to ☐ Present |
| | to ☐ Present |
| | to ☐ Present |
| | to ☐ Present |
| | to ☐ Present |
| | to ☐ Present |
| | to ☐ Present |

6. Do you have a driver's license? Yes ☐

*If yes,* state of issuance: _____ ; DL Number: _____

B. Other Lawsuits: Has Plaintiff ever been a party to a medical monitoring and/or personal injury lawsuit, *other than* in the present suit?

Yes ☐ No ☐

*If yes,* state: (1) nature of the case (2) the state and county in which claim was filed, (3) the caption, case name and/or names of adverse parties, (4) the civil action or docket number assigned to each such claim, action or suit, (5) attorney who represented you, (6) a description of the nature of your claim, (6) the current status of the claim, and (7) amount of damages or compensation received (unless subject to protective order or confidentiality agreement).

| Nature of the Case | State and County in which claim was filed | Caption, Case Name and/or names of adverse parties | Civil Action or Docket Number | Attorney who represented you | Description of the Nature of the claim and Current Status | Amount of damages or compensation received |
|---|---|---|---|---|---|---|
| | | | | | | |
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C. Convictions: Have you ever been convicted of, or pled guilty (or no contest) to, a felony and/or a crime involving fraud or dishonesty?

Yes ☐ No ☐

*If yes,* please provide the following information for each such conviction/guilty plea: (l) the crime or offense, (2) the state and county in which you were convicted or pled guilty or no contest, (3) the date on which you were convicted or pled guilty or no contest, and (4) the sentence or other outcome.

| Crime or Offense | State and County Where Proceedings Took Place | Date of conviction, guilty or no contest plea | Sentence or other outcome |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

D. Computer Use: Have you had access to a computer at any time during the past five (5) years?

Yes☐ No☐

*If yes,* then answer the following:

1. Did you visit within the past five years any website containing information regarding Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ) contamination with NDMA or other carcinogenic substances?
   Yes ☐ No ☐ Do Not Recall ☐

   If yes, identify the websites and the dates viewed:

2. Did you communicate in the past ten (10) years via email, visit any chat rooms, or publicly post a comment, message or blog entry on a public internet site regarding your health, Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ)? (You should include all postings on public social network sites including Twitter, Facebook, MySpace, Linkedln, or "blogs" where the general public may post such comments).

   Yes ☐ No ☐ Do Not Recall ☐

   *If yes*, please tell us where and when you made such public posts and the substance of what was posted.

E. Bankruptcy: Have you or your spouse ever filed for bankruptcy?

Yes ☐ No ☐

*If yes*, please state when and in what court you filed your bankruptcy petition, including the docket number of the petition and the date of the orders of discharge, if any:

| Date Bankruptcy Filed | Court in Which Bankruptcy was Filed | Docket Number | Discharge Date (if applicable) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

F. Employment History

**Whether or not** you are making a lost wage claim, please respond to all questions in this section except as noted:

1 . Are you currently employed? Yes ☐ No ☐

*If yes,* identify your current employer with name, address and telephone number and your title/position there:

Employer: _____

Address: _____

Telephone Number: _____

Title/Position: _____

a. Have you left this job for a medical reason in the past five years?

Yes ☐ No ☐

*If yes,* describe the medical condition and reason for leaving:

2. Have you been out of work for more than thirty (30) consecutive days for reasons related to your health in the past five (5) years?

Yes ☐ No ☐

*If yes,* please state the dates, employer, and the health condition causing your absence from work:

| Name of Employer | Dates | Health Condition |
|---|---|---|
| | to ☐ Present | |
| | to ☐ Present | |
| | to ☐ Present | |
| | to ☐ Present | |
| | to ☐ Present | |
| | to ☐ Present | |
| | to ☐ Present | |
| | to ☐ Present | |
| | to ☐ Present | |
| | to ☐ Present | |

G. Military Service

Have you ever served in any branch of the military? Yes ☐ No ☐

1. *If yes,* branch and dates of service:

| Branch | Dates of Service |
|---|---|
| | to ☐ Present |
| | to ☐ Present |
| | to ☐ Present |
| | to ☐ Present |

*If yes,* highest rank: _____

*If yes*, military occupational specialty ("MOS"): _____

*If yes,* were you discharged for any reason relating to your health (whether physical, psychiatric, or other health condition)? Yes☐ No ☐

*If yes*, state the health condition:

2. Have you ever been rejected from military service for any reason relating to your health (whether physical, psychiatric, or other health condition)?

Yes ☐ No ☐

*If yes,* state the health condition:

H. Worker's Compensation and Disability Claims: Have you ever filed for worker's compensation, related to a claim of occupational exposure to a carcinogenic substance, or for social security and/or state or federal disability benefits for any reason?

Yes ☐ No ☐

*If yes,* please then as to each application, separately state the following:

Year claim was filed: _____

Where claim was filed: _____

Claim/docket number, if applicable: _____

To what government agency or company did you submit your application:

_____

Nature of claimed injury: _____

Period of disability: _____

Amount awarded: _____

Was claim denied? Yes ☐ No ☐

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

I. Life Insurance: Within the last ten (10) years, have you ever been denied life insurance based on health reasons?

Yes ☐ No ☐

*If yes,* please state when, the name of the life insurance company, and the company's stated reason for denial (if any):

## III. **CLAIM INFORMATION**

A. Hypertension

Relevant History

a. When were you first diagnosed with hypertension?

b. If you discontinued the Valsartan products, how have you managed or treated your hypertension?

B. Valsartan

1. Are you currently taking Valsartan, Amlodipine/ Valsartan, Valsartan/ Hydrochlorothiazide (HCTZ), and/or Amlodipine/ Valsartan/ Hydrochlorothiazide (HCTZ)?

   Yes ☐ No ☐

2. Have you ever received any samples of Valsartan, Amlodipine/ Valsartan, Valsartan/ Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ)?

   Yes ☐ No ☐ Do Not Recall ☐

   *If yes,* please state the following: (1) who gave you the sample(s); (2) when the sample(s) were provided; and (3) how many sample(s) you received:

| Physician/Clinic/individual who provided samples | When Samples Were Provided | How Many Samples You Received |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| Physician/Clinic/individual who provided samples | When Samples Were Provided | How Many Samples You Received |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

3. Were you ever given any written instructions, including any prescriptions, packaging, package inserts, literature, medication guides, or dosing instructions, regarding Valsartan, Amlodipine/ Valsartan, Valsartan/ Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/ Hydrochlorothiazide (HCTZ)?

   Yes ☐ No ☐ Do Not Recall ☐

   *If yes,* please describe the documents if you no longer have them. If you have the documents, please produce them or make them available for inspection.

4. Were you given any oral instructions regarding your use of Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/ Valsartan/Hydrochlorothiazide (HCTZ)?

   Yes ☐ No ☐ Do Not Recall ☐

   *If yes,* please identify each person who gave you oral instructions about Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ) and describe what he or she told you:

5. Do you have in your possession, or does your attorney have, the container or packaging from the Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ) you allege to have used?

Yes ☐ No ☐

*If yes,* who currently has custody of the Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ) container or packaging?

6. Have you ever seen any advertisements *(e.g.,* in magazines or television commercials) for Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ)?

Yes ☐ No ☐ Do Not Recall ☐

*If yes,* identify the advertisement or commercial, state the nature and content of each advertisement or commercial, and approximately when you saw the advertisement or commercial:

7. Other than through your attorneys, have you had any communication, oral or written, with any of the Defendants or their representatives regarding the Valsartan recall?

Yes ☐ No ☐ Do Not Recall ☐

*If yes,* please identify:

Date of Communication: _____

Method of Communication: _____

Name of Defendant/representative: _____

Substance of communication between you and any representative(s) of the Defendants:

C. **Pharmacies**:

Identify each pharmacy, drugstore, and/or other supplier (including mail order) where you have had prescriptions filled or from which you have received any prescription medication in the past ten (10) years (attach additional sheets as necessary):

| Name of Pharmacy | Address and Phone Number of Pharmacy | Approximate Dates |
|---|---|---|
| | Tel.: | to ☐ Present |
| | Tel.: | to ☐ Present |
| | Tel.: | to ☐ Present |
| | Tel.: | to ☐ Present |
| | Tel.: | to ☐ Present |
| | Tel.: | to ☐ Present |
| | Tel.: | to ☐ Present |
| | Tel.: | to ☐ Present |
| | Tel.: | to ☐ Present |
| | Tel.: | to ☐ Present |

D. Insurance Carriers: Identify each health insurance carrier which provided you with medical coverage and/or pharmacy benefits for the last ten (10) years, and the policy number (attach additional sheets as necessary).

| Carrier | Policy Number | Approximate Dates of Coverage |
|---|---|---|
| | | to ☐ Present |
| | | to ☐ Present |
| | | to ☐ Present |
| | | to ☐ Present |
| | | to ☐ Present |
| | | to ☐ Present |
| | | to ☐ Present |
| | | to ☐ Present |
| | | to ☐ Present |
| | | to ☐ Present |
| | | to ☐ Present |
| | | to ☐ Present |

**Cancer Diagnoses:** Have you ever been diagnosed with any type of cancer?

Yes ☐ No ☐

If "yes", please identify each type of cancer and the date of diagnosis.

| Cancer Type | Date of Diagnosis |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

E. Screening and Diagnostics

1. Procedures and/or Treatments.

a. Identify any medical providers providing treatment based on your use of Valsartan, Amlodipine/Valsartan, Valsartan/ Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/ Hydrochlorothiazide (HCTZ):
Medications Prescribed

| Medical Providers | Medication Prescribed |
|---|---|
| | |
| | |
| | |
| | |

| Medical Providers | Medication Prescribed |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

b. Please list medical, diagnostic, testing, and screening procedures, which you have undergone with regard to a potential or confirmed cancer diagnosis in the last 10 years?

| Treatment/Procedure | Reason for Treatment/Procedure | Date of Treatment/ Procedure |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Treatment/Procedure | Reason for Treatment/Procedure | Date of Treatment/ Procedure |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

c. For each treatment and/or procedure for which you answered Yes in the previous chart, please provide the information requested below:

| Name of health care provider(s) | Address and Phone Number |
|---|---|
| | Tel.: |
| | Tel.: |
| | Tel.: |
| | Tel.: |

| Name of health care provider(s) | Address and Phone Number |
|---|---|
| | Tel.: |
| | Tel.: |
| | Tel.: |
| | Tel.: |
| | Tel.: |
| | Tel.: |
| | Tel.: |
| | Tel.: |

F. Risk Factors

1. Have you ever had regular exposure to (select all that apply):

| Exposure to: | Type/Frequency | Dates of Exposure |
|---|---|---|
| Cadmium (i.e., battery production, cadmium mining) | Occupational ☐ Other ☐ | |
| Coal industry | Occupational ☐ Other ☐ | |
| Diet includes red and/or processed meats | Approximately _____ meals per week | |
| Diet includes smoked foods, salted meat and fish, and/or pickled vegetables | Approximately _____ meals per week | |
| Metal industry (i.e., steel facilities, smelting) | Occupational ☐ Other ☐ | |
| Organic solvents (i.e., trichloroethylene, perchloroethylene, methylene chloride) | Occupational ☐ Other ☐ | |
| Pesticides (includes herbicides) | Occupational ☐ Other ☐ | |
| Radiation (i.e., therapeutic radiation, thorotrast radiography, nuclear industry work) | Occupational ☐ Other ☐ | |
| Rubber industry | Occupational ☐ Other ☐ | |
| Vinyl chloride | Occupational ☐ Other ☐ | |

2. Tobacco Use History:

Did you use tobacco, including cigarettes, cigars, pipes, and/or chewing tobacco/ snuff at any time?

Yes ☐ No ☐

If you answered yes, please identify the types of tobacco used and the amount used.

Types of tobacco used: cigarettes ☐ cigars ☐ vaping ☐
pipes ☐ chewing tobacco/snuff ☐

Date tobacco use started: _____

Date tobacco use ceased: _____

Amount used: on average, _____ per day for _____ years

3. Alcohol Use History

Do you currently or have you in the past drank alcohol (beer, wine, whiskey, etc.)?

*If yes, p*lease check which of the following represents your typical alcohol consumption in the ten (10) years leading up the date on which you first experienced any symptoms you believe are related to your alleged injury(ies):

☐ 1-2 drinks per week

☐ 3-6 drinks per week

☐ 7-10 drinks per week

☐ 10 or more drinks per week

☐ Other - explain: _____

Type of Alcohol Consumed:

4. Have you been diagnosed with, or treated for any of the following in the past ten (10) years? If so, for each condition for which you answer yes, please provide the additional information requested below:

| Condition | Yes | No | Unknown |
|---|---|---|---|
| Cancer of any type prior to Valsartan use /other than the cancers alleged above (Including, but not limited to, lung, colon, liver, breast, kidney, skin, stomach, testicular, leukemia, Hodgkin's disease, or Non-Hodgkin's lymphoma) | ☐ | ☐ | ☐ |
| Celiac Disease | ☐ | ☐ | ☐ |
| Cirrhosis | ☐ | ☐ | ☐ |
| Colon polyps | ☐ | ☐ | ☐ |
| Common variable immunodeficiency (CVID) | ☐ | ☐ | ☐ |
| Persistent Constipation | ☐ | ☐ | ☐ |
| Diagnosed and Treated Depression/ Anxiety | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ |
| Persistent Diarrhea | ☐ | ☐ | ☐ |

| Condition | Yes | No | Unknown |
|---|---|---|---|
| Encephalitis | ☐ | ☐ | ☐ |
| Epstein-Barr virus | ☐ | ☐ | ☐ |
| Gallbladder disease | ☐ | ☐ | ☐ |
| Gastrointestinal bleeding | ☐ | ☐ | ☐ |
| Genetic condition(s) (list all) | ☐ | ☐ | ☐ |
| Gluten sensitivity or intolerance | ☐ | ☐ | ☐ |
| Hepatic dysfunction or active liver disease | ☐ | ☐ | ☐ |
| Hemochromatosis | ☐ | ☐ | ☐ |
| Hepatitis B virus | ☐ | ☐ | ☐ |
| Hepatitis C virus | ☐ | ☐ | ☐ |
| H pylori | ☐ | ☐ | ☐ |
| Human immunodeficiency virus (HIV) | ☐ | ☐ | ☐ |
| Human papillomavirus | ☐ | ☐ | ☐ |
| Hyperlipidemia | ☐ | ☐ | ☐ |
| Hypertension (High Blood Pressure) | ☐ | ☐ | ☐ |
| Hypotension (Low Blood Pressure) | ☐ | ☐ | ☐ |
| Intestinal obstruction | ☐ | ☐ | ☐ |
| Increased C-Reactive Protein (CRP) levels | ☐ | ☐ | ☐ |
| Inflammatory Bowel Disease | ☐ | ☐ | ☐ |
| Irritable Bowel Syndrome | ☐ | ☐ | ☐ |
| Jaundice | ☐ | ☐ | ☐ |
| Kidney Problems (disease, infections, stones, protein in urine, etc.) | ☐ | ☐ | ☐ |

| Condition | Yes | No | Unknown |
|---|---|---|---|
| Liver dysfunction | ☐ | ☐ | ☐ |
| Liver tumor | ☐ | ☐ | ☐ |
| Malabsorption | ☐ | ☐ | ☐ |
| Persistent Nausea | ☐ | ☐ | ☐ |
| Non-cancerous tumors | ☐ | ☐ | ☐ |
| Diagnosed Obesity | ☐ | ☐ | ☐ |
| Pancreatic cysts | ☐ | ☐ | ☐ |
| Pancreatic insufficiency | ☐ | ☐ | ☐ |
| Pulmonary Embolism /blood clot in lung | ☐ | ☐ | ☐ |
| Refractory celiac disease | ☐ | ☐ | ☐ |
| Renal Insufficiency | ☐ | ☐ | ☐ |
| Retinal bleed | ☐ | ☐ | ☐ |
| Stomach ulcers/Peptic ulcers (requiring surgery) | ☐ | ☐ | ☐ |
| Stomach polyps | ☐ | ☐ | ☐ |
| Stroke of any type (hemorrhagic, ischemic, etc.) | ☐ | ☐ | ☐ |
| Transient Ischemic Attack (TIA) | ☐ | ☐ | ☐ |
| Typhoid Fever | ☐ | ☐ | ☐ |
| Ulcerative Colitis | ☐ | ☐ | ☐ |
| Sudden, substantial weight loss | ☐ | ☐ | ☐ |
| Persistent Vomiting | ☐ | ☐ | ☐ |

**G.** For each condition for which you answered yes in the previous chart, please provide the information requested below (attach additional sheets as necessary).

| Condition | Name, Address, and Phone Number of Treating Health Care Provider | Approximate Date of Onset | Treatment Received and Outcome |
|---|---|---|---|
| | Tel.: | | |
| | Tel.: | | |
| | Tel.: | | |
| | Tel.: | | |
| | Tel.: | | |

| Condition | Name, Address, and Phone Number of Treating Health Care Provider | Approximate Date of Onset | Treatment Received and Outcome |
|---|---|---|---|
| | Tel.: | | |
| | Tel.: | | |
| | Tel.: | | |
| | Tel.: | | |
| | Tel.: | | |

| Condition | Name, Address, and Phone Number of Treating Health Care Provider | Approximate Date of Onset | Treatment Received and Outcome |
|---|---|---|---|
| | Tel.: | | |
| | Tel.: | | |
| | Tel.: | | |
| | Tel.: | | |
| | Tel.: | | |

| Condition | Name, Address, and Phone Number of Treating Health Care Provider | Approximate Date of Onset | Treatment Received and Outcome |
|---|---|---|---|
| | Tel.: | | |
| | Tel.: | | |
| | Tel.: | | |
| | Tel.: | | |
| | Tel.: | | |

| Condition | Name, Address, and Phone Number of Treating Health Care Provider | Approximate Date of Onset | Treatment Received and Outcome |
|---|---|---|---|
| | Tel.: | | |
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| Condition | Name, Address, and Phone Number of Treating Health Care Provider | Approximate Date of Onset | Treatment Received and Outcome |
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| | Tel.: | | |
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| Condition | Name, Address, and Phone Number of Treating Health Care Provider | Approximate Date of Onset | Treatment Received and Outcome |
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| | Tel.: | | |
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| Condition | Name, Address, and Phone Number of Treating Health Care Provider | Approximate Date of Onset | Treatment Received and Outcome |
|---|---|---|---|
| | Tel.: | | |
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| Condition | Name, Address, and Phone Number of Treating Health Care Provider | Approximate Date of Onset | Treatment Received and Outcome |
|---|---|---|---|
| | Tel.: | | |
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| | Tel.: | | |

| Condition | Name, Address, and Phone Number of Treating Health Care Provider | Approximate Date of Onset | Treatment Received and Outcome |
|---|---|---|---|
| | Tel.: | | |
| | Tel.: | | |
| | Tel.: | | |

## IV. MEDICATIONS

In the past ten (10) years, list the following for any prescription medications you took for treatment of the medical conditions identified in Part III.B above:

| Name of Prescription Medication | Healthcare provider(s) that prescribed the medication | Approximate dates/years taken | Dosage and frequency of use | Reason for prescription | Name and address of pharmacy |
|---|---|---|---|---|---|
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |

| Name of Prescription Medication | Healthcare provider(s) that prescribed the medication | Approximate dates/years taken | Dosage and frequency of use | Reason for prescription | Name and address of pharmacy |
|---|---|---|---|---|---|
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |

| Name of Prescription Medication | Healthcare provider(s) that prescribed the medication | Approximate dates/years taken | Dosage and frequency of use | Reason for prescription | Name and address of pharmacy |
|---|---|---|---|---|---|
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
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| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |

| Name of Prescription Medication | Healthcare provider(s) that prescribed the medication | Approximate dates/years taken | Dosage and frequency of use | Reason for prescription | Name and address of pharmacy |
|---|---|---|---|---|---|
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |
| | | to<br>☐ Present | | | |

## V. FRAUD CLAIMS

1. Are you claiming fraud or consumer fraud in this action on the basis of Plaintiff-specific allegations other than those set forth in the Master and Short Form Complaints?

   Yes ☐ No ☐

   *If yes*, please answer the following questions:

2. What representation(s) do you claim was falsely or fraudulently made and to whom was it made?

3. By whom?

4. How was it made?

5. When was the alleged representation(s) made? Identify approximate date(s).

6. Were these representations in writing? Yes ☐ No ☐

7. If the representations were in writing, did you retain and currently have the original or a copy of those representations? Yes ☐ No ☐

## VI. DOCUMENT DEMANDS

A. AUTHORIZATIONS [To be served within twenty (20) days after service of the Plaintiff Fact Sheet ("PFS")]

**1. Health Care Authorizations - For each health care provider identified in Section III.C, Section III.E, Section III.G, and Section IV of this Fact Sheet, please provide a completed and signed (but undated) Health Care Authorization in the form attached as Exhibit "A."**

**2. Insurance Records Authorization - For each insurance company identified in Section III.D of this Fact Sheet, please provide a completed and signed (but undated) Authorization for Release of Insurance Records in the form attached as Exhibit "B."**

**3.** Authorization for Release of Workers' Compensation Records

a) Only if you answered "Yes" to question II.H in the PFS and have previously applied for Worker's Compensation related to a claim of occupational exposure to a carcinogenic substance, please provide a completed and signed (but undated) Authorization for Release of Workers' Compensation Records for each government agency or employer company you submitted your application to in the last ten (10) years in the form attached as **Exhibit "C."**

b) If you answered "No" to question II.H in the PFS you are not required to provide Release of Workers' Compensation Records.

**4.** Authorization for Release of Disability Records

a) Only if you answered "Yes" to question II.H in the PFS and have previously applied for Disability benefits, please provide a completed and signed (but undated) Authorization for Release for each government agency or company you submitted your application to in the last ten (10) years in the form attached as **Exhibit "D."**

b) If you answered "No" to question II.H in the PFS you are not required to provide Release of Disability Records.

B. OTHER RELEVANT DOCUMENTS DEMANDS

Requests for any non-privileged documents in your possession or the possession of your lawyers, including writings on paper or in electronic form (if you have any of the following materials in your custody or possession or the possession of your lawyers). Please indicate by answering "Yes" or "No" which documents you have, and attach a copy of each of those you have to this Plaintiff Fact Sheet with your responses to the questions above:

1. All non-privileged documents you reviewed that assisted you in the preparation of the answers to this Plaintiff Fact Sheet.

*Responsive Documents Attached* ☐

*I have no documents responsive to this request* ☐

2. A copy of all medical records and/or documents relating to the use of Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ) from any hospital or health care provider who treated you in the past fifteen (15) years.

*Responsive Documents Attached* ☐

*I have no documents responsive to this request* ☐

3. All documents, including but not limited to, personal or professional letters, diaries, calendars, journals, logs, date books, video or audio tapes or other documents, materials or things of Plaintiff's or any member of Plaintiff's family, relating to or reflecting your use of any prescription drug or medication in the past ten (10) years, including documents sufficient to identify all medications that you have taken.

*Responsive Documents Attached* ☐

*I have no documents responsive to this request* ☐

4. All documents constituting, concerning, or relating to product use instructions, product warnings, package inserts, medication guides, pharmacy handouts, or other materials distributed with or provided to you in connection with your use of Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ).

*Responsive Documents Attached* ☐

*I have no documents responsive to this request* ☐

5. Copies of advertisements or promotions for Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ) and articles discussing Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ), including but not limited to, legal advertisements or promotions related to the recall or this litigation.

*Responsive Documents Attached* ☐

*I have no documents responsive to this request* ☐

6. Copies (or photos were applicable) of the packaging, including the container/ packaging and label for Valsartan, Amlodipine/Valsartan, Valsartan/ Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ) (plaintiffs or their counsel must maintain the originals of the items requested in this subpart).
*Responsive Documents Attached* ☐
*I have no documents responsive to this request* ☐

7. All documents relating to your purchase of Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/ Hydrochlorothiazide (HCTZ) including, but not limited to, receipts, prescriptions, prescription records, containers, labels, or records of purchase.
*Responsive Documents Attached* ☐
*I have no documents responsive to this request* ☐

8. All documents known to you and in your possession which mention Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/ Valsartan/Hydrochlorothiazide (HCTZ), or any alleged health risks or hazards related to Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ) in your possession at or before the time of the injury alleged in your Complaint, other than legal documents, documents provided by your attorney, or documents obtained or created for the purpose of seeking legal advice or assistance.
*Responsive Documents Attached* ☐
*I have no documents responsive to this request* ☐

9. All documents in your possession or in the possession of anyone acting on your behalf (not your lawyer) obtained directly or indirectly from any of the Defendants regarding the valsartan recall.
*Responsive Documents Attached* ☐
*I have no documents responsive to this request* ☐

10. All documents constituting any communications or correspondence between you and any representative of the Defendants regarding the valsartan recall.
*Responsive Documents Attached* ☐
*I have no documents responsive to this request* ☐

11. Copies of all documents you (and not your lawyer) obtained from any source relating to Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ) or to the alleged effects of using Valsartan, Amlodipine/Valsartan, Valsartan/ Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ), including but not limited to legal advertising materials relating to the recall or this litigation.
*Responsive Documents Attached* ☐
*I have no documents responsive to this request* ☐

12. Any and all documentation of Plaintiff's use of social media, Internet postings, or other electronic networking website (including, but not limited to, Facebook, MySpace, Linkedin, Google Plus, Windows Live, YouTube, Twitter, Instagram, Pinterest, blogs, and Internet chat rooms/message boards) relating to the recall of Valsartan, Amlodipine/Valsartan, Valsartan/Hydrochlorothiazide (HCTZ), and/or Amlodipine/Valsartan/Hydrochlorothiazide (HCTZ), or any of your claims in this lawsuit.
*Responsive Documents Attached* ☐
*I have no documents responsive to this request* ☐

13. All public statements made by or on behalf of you relating to this litigation in your possession.
*Responsive Documents Attached* ☐
*I have no documents responsive to this request* ☐

14. All bankruptcy petitions and orders of discharge (if applicable) for all bankruptcy claims made by you or your spouse since the date of your first use of Valsartan Products.
*Responsive Documents Attached* ☐
*I have no documents responsive to this request* ☐

## VII. DECLARATION

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information and belief formed after due diligence and reasonable inquiry, that I have supplied all the documents requested in Part XI of this Plaintiff Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied/will supply all applicable Authorizations attached to this declaration, in accordance with the terms of this Plaintiff Fact Sheet.

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.

_____ _____

Plaintiff's Name (Signature) Date

_____

Plaintiff's Name (Printed)