UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
PENSACOLA DIVISION

IN RE: DEPO-PROVERA (DEPOT MEDROXYPROGESTERONE ACETATE) PRODUCTS LIABILITY LITIGATION	**Case No. 3:25-md-3140**
This Document Relates to: All Cases	**Judge M. Casey Rodgers** **Magistrate Judge Hope T. Cannon**

PLAINTIFF FACT SHEET

This Fact Sheet is to be completed by each Plaintiff in this litigation (hereafter referred to as "you" or "Plaintiff") as required by Case Management Order No. 14 (Case Management Order For Ongoing Litigation Against Defendants) in connection with *In re Depo-Provera (Depot Medroxyprogesterone Acetate) Products Liability Litigation* (MDL 3140).

In completing this Fact Sheet, you are under oath and must answer every question and provide information that is true and correct to the best of your knowledge after a reasonable investigation. You are required to provide as much information as you can in response to each question. You are also required to conduct a reasonable inquiry, to the extent necessary, to obtain or confirm the information you provide in this Fact Sheet. Likewise, if any information you need to complete any part of the Fact Sheet is in the possession of your attorney, please consult with your attorney so that you can fully and accurately respond to the questions set out below. If you are completing the Fact Sheet for someone who cannot complete the Fact sheet himself or herself, please answer as completely as you can.

All responses must be made without objection and to the best of your knowledge and recollection. Use additional sheets if necessary to answer any question completely. If additional sheets are used to provide further answers to any question, you should indicate on the form that additional pages will be used and should include those pages in the verification of the Plaintiff Fact Sheet.

A completed Fact Sheet will be considered interrogatory answers pursuant to the Federal Rules of Civil Procedure Rule 33 and answers to Requests for

Admission pursuant to Federal Rule of Civil Procedure Rule 36. As such, admissions regarding matters contained in this verified Plaintiff Fact Sheet will be treated as conclusively established party admissions unless supplemented by Plaintiff in an amended Plaintiff Fact Sheet verified by the Plaintiff or the Court, on motion, permits the admission to be withdrawn or amended. You must promptly supplement your responses if you learn that they are incomplete or incorrect in any material respect.

Pursuant to the Court's CMO No. 14, each plaintiff must complete and submit this Plaintiff Fact Sheet by the deadlines set forth in Section VI of the Order. All Plaintiff Fact Sheets and Verification pages must be served on the defendants via each plaintiff's individual MDL Centrality portal with the correct MDL Centrality document description provided for each document. Consistent with CMO No. 14, a failure to provide a complete and verified Plaintiff Fact Sheet by the necessary deadlines may result in dismissal with prejudice.

I. CASE INFORMATION

1. Current MDL Centrality Plaintiff ID Number: _____

   a. Prior MDL Centrality Plaintiff ID Numbers, if any: _____

2. Current MDL Case Number: _____

3. Date Current MDL Case Filed: _____

4. Current Law Firm: _____

5. All law firms who have represented You in connection with Your depot medroxyprogesterone acetate (DMPA) Claim(s):

Law Firm	Start Date of Representation	End Date of Representation

6. Prior Case Numbers (if any):

Case Number	Court/Venue	Status	Date of Dismissal (if any)

7. When did you first become aware of litigation/lawsuits relating to Depo-Provera or DMPA?

   Month: _____ Year: _____

8. Describe how you first learned of the litigation: _____

   _____

9. When did you first attempt to contact a lawyer about Your potential claim relating to Depo-Provera use? (MM/YYYY): _____

II. PLAINTIFF INFORMATION

Please provide the following information for the individual on whose behalf the action was filed.

1. Name (First, Middle, and Last):_____

2. Maiden name or other names used by You, or by which You have known and the dates those names were used:

Previous Name	Years Used	Reason for change

3. Social Security Number: _____

4. Date of Birth (MM/DD/YYYY): _____

5. Biological Sex at Birth: ☐ Female ☐ Male

6. Current Residence (full address):

   Number and Street: _____

   City: _____ State: _____ Zip Code: _____

7. Number of Years at Current Residence: _____

8. List Your residential addresses in the year(s) You used DMPA:

Number and Street	City, State, ZIP	Years There

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

9. Name (First, Middle, and Last):_____

10. Current Residence (full address):

    Number and Street: _____

    City: _____ State: _____ Zip Code: _____

11. Capacity in which you are representing the individual: _____

12. If you were appointed as a representative by a court, identify the state, court and case number:

    _____

13. Relationship to the represented person: _____

14. Date of death of the decedent: _____

15. Place of death of the decedent (city, state, country):

    _____

16. Was an autopsy performed? ☐ Yes ☐ No

    If yes, provide the name and address of the facility where the autopsy was performed and attach a copy of the autopsy report: _____

17. List all social media profiles (including MySpace, Facebook, Twitter/X, LinkedIn, TikTok, Instagram, Yelp or any others) and associated account name or user names You have ever used:

Social Media Platform (Facebook, Instagram, etc.)	Account or username or handle

18. Describe the highest level of education You have attained:

    _____

19. List all employment experience starting five years prior to Your first use of DMPA through the present:

Occupation	Employer Name and Address	Dates of Employment

20. Have you ever served in the military? ☐ Yes ☐ No

If yes, please provide dates and military branch: _____

_____

21. Have You ever been rejected from employment or military service related to health or disability reasons? ☐ Yes ☐ No

22. Have You ever filed a worker's compensation claim, social security claim, or lawsuit (including any bankruptcy or divorce proceedings)? ☐ Yes ☐ No

If yes , identify the parties, case number, jurisdiction, date initiated, subject matter/allegations, and disposition, to the extent known:

Year	Where Filed	Subject Matter	Status/Disposition

III. FAMILY

1. Current marital status:

☐ Married ☐ Unmarried – Living with Partner

☐ Unmarried – Not Living with Partner ☐ Single

2. If married, please provide the following information for Your spouse:

   Name: _____

   Current Age: _____

   Year of Marriage (YYYY): _____

   If married, is Your spouse asserting a Loss of Consortium claim: ☐ Yes ☐ No

3. Have you previously been married? ☐ Yes ☐ No

   If yes, please provide the following information about Your former spouse(s):

Full Name	Year of Marriage	Year of Divorce

4. Do you have any children? ☐ Yes ☐ No

   If you have any children, please provide the following information regarding each child:

Full Name	Year Born (YYYY)	Does the child live with You?

5. List all of the people who currently live with You at Your residence, along with their relationship to You who are not already listed in response to III.2, III.3, or III.4:

Full Name	Age	Relationship to You	How long has the person lived with You?

IV. PRODUCT USE

1. List Your FIRST use of DMPA (MM/YYYY): _____

2. List Your LAST use of DMPA (MM/YYYY): _____

3. For what reason(s) were You prescribed DMPA?

☐ Contraception ☐ Endometriosis

☐ Excessive bleeding ☐ Other (please describe):

4. Please provide the below additional information about Your DMPA use:

DMPA or medroxyprogesterone product used[1]	Start Date (MM/YYYY)	Stop Date (MM/YYYY)	Medical Facility	Medical Facility Address	If online or home delivery pharmacy, provide Member ID

[1] Options are: Depo-Provera (IM injection); Depo-SubQ Provera 104 (subcutaneous injection); Provera (tablets); medroxyprogesterone acetate (IM injection); medroxyprogesterone acetate (subcutaneous injection); medroxyprogesterone acetate (tablets); or other.

V. MENINGIOMA DIAGNOSIS

1. Please select any and all diagnoses that You allege are related to Your DMPA use (check all that apply:

   ☐ Intercranial meningioma ☐ Spinal meningioma ☐ Other Injuries:

   _____

2. Have You been diagnosed with more than one meningioma? ☐ **Yes** ☐ **No**

   If Yes, How Many?

   _____

3. When was the FIRST time (month and year) you were diagnosed with the injury above?

   _____

4. When was the FIRST time (month and year) you complained of symptoms related to the diagnosis for the injury above?

   _____

5. For each of the above, please provide the date You were diagnosed with that injury, and the name and address of the health care provider or clinician who diagnosed you:

Date of Diagnosis	Name of Diagnosing Provider	Location of Diagnosing Provider

6. Have you received treatment for your meningioma diagnosis? (Check all that apply)

   □ Yes, radiation (Number of sessions: _____)

   □ Yes, radiation (Surgery was not Medically Feasible. Name of Diagnosing Provider: _____)

   □ Yes, surgery

   □ No treatment

   □ Other treatment (please identify): _____

7. If You have received treatment for your meningioma, please identify the dates of your treatment and location of your treating physicians or other health care providers:

Treatment type (radiation, surgery)	Date(s) of treatment	Name of Treating Health Care Provider/Clinic	Location of Treating Health Care Provider/Clinic

8. What was the last date of treatment or medical care for your meningioma?

_____

9. If you are under active surveillance, is your meningioma currently stable?

☐ Yes ☐ No ☐ I don't know

10. Are You alleging that you have suffered any permanent injuries (such as blindness, blurred vision, numbness, paralysis, or headaches) resulting from Your meningioma diagnosis or treatment?

☐ Yes ☐ No ☐ I don't know

If yes, please describe: _____

11. Has any healthcare provider told you that any injury identified above is related to your Depo-Provera / medroxyprogesterone acetate use? □ Yes □ No □ I don't know

If yes, please state the name and address (city and state) of each such provider:

If yes, please state the name and address (city and state) of each such provider:

_____

_____

VI. MEDICAL HISTORY

1. Identify each primary care provider, neurologist, neurosurgeon, gynecologist (including any ob-gyn), hospital or other facilities who have seen or treated you during the time-period beginning ten (10) years prior to your first use of Depo-Provera / medroxyprogesterone acetate through the present:

Name	Specialty	Years Seen	Reason for Seeing

2. Identify each medical and/or prescription medication insurance plan you have held for the five (5) years prior to your first use of Depo-Provera / medroxyprogesterone acetate to the present [please also identify times when self-insured or uninsured]:

Name of Insurance Plan	Date(s) (MM/YYYY)

3. Identify the forms of contraception that You have used, and the dates (MM/YYYY) of use:

Contraceptive Method	Dates of Use

4. Please indicate whether you have ever experienced, been diagnosed with, or been treated for any of the following conditions.

Condition	Yes	No	Unknown
Breast cancer			
Neurofibromatosis type 2 (NF2)			
Cowden syndrome			
Gorlin syndrome			
Werner syndrome			
Diagnosed obesity			
BAP 1 mutation			
Non-Cancerous tumors			
Headache/Migraine			
Seizure Disorder			
Visual Impairment/Blurred Vision			
Diplopia			
Hearing Loss/Tinnitus			
Dizziness or Vertigo			
Anosmia			
Ataxia			
Hemiparesis			
Focal Neurologic Deficit			
Paresthesia			
Aphasia			
Cognitive Impairment			
Dementia			
Dysarthria			
Hydrocephalus			

5. Current Height: _____

6. Current Weight: _____

7. Weight at time of Meningioma Diagnosis: _____

8. Have you ever used hormone replacement therapy? ☐ Yes ☐ No

   If yes, identify:

   Product(s) used: _____

   Name and Address of prescriber: _____

   Dates/timeframe used: _____

9. Have you ever had radiation treatment to your head? If so, please provide the dates and locations of your treatment:

Dates of Treatment	Reason for Treatment	Name of Treater or Clinic	Location of Treater or Clinic

10. Have any of your blood relatives been diagnosed with meningioma (i.e., parents, grandparents, children, siblings, aunts/uncles)? ☐ Yes ☐ No ☐ I don't know

11. If yes, provide the relative's relationship to you, location of meningioma, age at diagnosis, treatment received, and prognosis/outcome:

    _____

12. Have you been screened or tested for any genetic risk factor associated with meningioma? □ Yes □ No □ I don't know

VII. DAMAGES

1. Do you claim, or plan to claim, that you have suffered emotional, mental, or psychological injury as a result of Your Depo-Provera / medroxyprogesterone acetate use? ☐ Yes ☐ No

   If yes, state the nature and the dates of the alleged injury and healthcare provider(s) who have treated you for such injury: _____

   _____

2. Have you paid or incurred any medical expenses, including amounts billed or paid by insurers and other third-party payors, which are related to any condition which you claim was caused by Depo-Provera and/or medroxyprogesterone acetate for which you seek recovery in the action which you have filed? ☐ Yes ☐ No

   If yes, please provide the best estimate of the total amount of such expenses:

   $_____

3. Do you claim or expect to claim that you lost earnings or suffered impairment of earning capacity as a result of any condition that you believe was caused by Depo-Provera and/or medroxyprogesterone acetate? ☐ Yes ☐ No. If yes state:

   The total amount of time for which lost wages will be claimed:
   $_____

   Your earned income for the time period beginning five (5) years prior to your first use of Depo-Provera / medroxyprogesterone acetate through the present:

Year	*Income*
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____

VIII. VERIFICATION

I declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information, and belief formed after a reasonable inquiry. I understand that I am under an obligation to supplement these responses.

Date:_____ Name: _____

Signature:_____