UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
THIRD DIVISION

In re: Guidant Corp. Implantable Defibrillators Products Liability Litigation	MDL No. 1708 (DWF/AKB)
This Document Relates to All Actions	**PLAINTIFF'S FACT SHEET**

PLAINTIFF'S FACT SHEET

Each Plaintiff who was implanted with a Guidant defibrillator or a pacemaker or combination defibrillator/pacemaker 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, information and belief. If you cannot recall all the details requested, please provide as much information as you can if the response to any question is that the person completing this Fact Sheet does not know or does not recall the information requested, that response should be entered in the appropriate location(s). You may and should consult with your attorney, if you have any questions regarding the completion of this form.

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

If you do not know an answer or a question does not apply to you, or you cannot remember an answer, then fill in the blank with "N/A" or "I don't know" or "I don't remember". Its important to FILL IN EVERY LINE.

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I. CASE INFORMATION

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

1. Case Caption: ____

____

2. Please state name, street address, telephone number, fax number and E-mail address of primary 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 questionnaire in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following about you, the representative:

1. ____
The Representative's Name:

2. ____
The Representative's Street Address:

3. ____
City, State and Zip Code

4. In what capacity are you representing the deceased or a minor (for example, beneficiary under the will, representative of the estate, executor of the estate, or guardian):

____

5. If you were appointed by a court in a representative capacity, identify the:

____________________________ _______________________________
Court Date of Appointment

6. Your relationship to deceased or represented person:

____

7. If you represent a decedent's estate, state the date of death and cause of death of the decedent.

____

[If you are completing this questionnaire in a representative capacity, please respond to the remaining questions in this Fact Sheet with respect to the person who received a Guidant Implantable Defibrillator and/or Pacemaker. Those questions using the term "You" refer to the person who received an implantable defibrillator and/or pacemaker. If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.]

C. Alleged Injuries:

1. Do you claim that you have suffered a physical injury as the result of the use of a Guidant implantable defibrillator and/or pacemaker?

Yes _______ No _______

2. If the answer to the foregoing question is "Yes," state the nature of the injury or injuries which you claim.

____

3. If you do not claim you have suffered a physical injury as the result of the use of a Guidant implantable defibrillator and/or pacemaker, state how you have been injured or describe the losses you are claiming.

____

II. PERSONAL INFORMATION

A. Last Name: ____

First Name: ____

Middle Name: ____

B. Maiden or other names used or by which you have been known, including alias/nicknames:

____

____

C. Present Street Address:

____
Street

____
City, State and Zip Code

D. Current or last occupation:

____

E. Social Security Number: ______________________________
.
F. Place of Birth: ______________________________

G. Date of Birth: ______________________________

H. Sex: Male: ________ Female ________

IF YOU ARE MAKING A CLAIM FOR PHYSICAL INJURIES:

Answer questions I-K.

IF YOU ARE NOT MAKING A CLAIM FOR PHYSICAL INJURIES, skip to SECTION III.

I. Have you filed a worker's compensation claim in the last ten (10) years?

Yes ________ No ________

If yes, please state

1. Year claim was filed: ______________________________
2. Where was the claim filed: ______________________________
3. Claim/docket number, if applicable: ____________________
4. Nature of disability: ______________________________
5. Period of disability: ______________________________
6. Street address of claims office: ______________________________

____

7. Whether the claim was settled and amount of any settlement:

____

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

J. Have you ever filed a social security disability claim within the last ten years?

Yes ________ No __________

1. If yes, please state

a. Year claim was filed: ______________________________

b. Where claim was filed: ______________________________

c. Nature of disability: ______________________________

d. Period of disability: ______________________________

e. Street address of claims office: ______________________________

f. Monthly amount of any disability payments: ______________________

g. Amount of any lump sum settlement: ______________________

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

K. Have you ever filed a lawsuit or made a claim, other than the present lawsuit, relating to any physical injury?

Yes ________ No _________

If yes, state:

1. The courts in which your other lawsuits were filed:

____

2. The civil action or docket number assigned to each such lawsuit

____

3. State whether you have ever testified under oath (e.g., in a courtroom or in a deposition) in any of these lawsuits.

____

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III. MARITAL STATUS

A. Are you currently married?

Yes ________ No __________

B. Has your spouse filed a loss of consortium claim?

Yes ________ No __________

C. Spouse's name: ____

D Spouse's date of birth: ____

E Spouse's occupation: ____

F If not currently married, do you have any former spouses who have filed loss of consortium claims?

Yes ________ No __________

G. If any former spouses have filed loss of consortium claims, please provide:

1. Name of former spouse: ______________________________________

2. Date of birth of former spouse: ________________________________

3. Date of marriage to former spouse: ______________________________

4. Date of dissolution of marriage from former spouse: ________________

IV. IMPLANT/EXPLANT INFORMATION

If you received a Guidant implantable defibrillator and/or pacemaker, for which you are making a claim of injury, then <u>for each device</u>, please answer the following questions:

A. Implantation Data:

1. The date of implantation: ______________________________________

2. The name and street address of your doctor who told you that you need to have the implantable defibrillator and/or pacemaker implanted: ____________________

____

____

3. The name and street address of the implanting surgeon: ____________________

____

____

4. The specific make, model, lot number and serial number of the Guidant implantable defibrillator and/or pacemaker you received:

____

5. Name of medical facility where implant was conducted: ____________________

____

____

B. After your Guidant defibrillator and/or pacemaker was implanted, did you participate in regular follow up with your doctor(s) about it.

Yes ________ No ________ I don't know ________

If yes:

1. Please estimate how frequently you follow(ed) up with your doctor(s) about your Guidant defibrillator and/or pacemaker

____

2. During this follow up, was your Guidant defibrillator and/or pacemaker ever tested by a doctor or a Guidant representative

Yes ________ No ________ I don't know ________

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If yes, please provide:

a. Dates of testing: ____

b. Facility where testing took place (name & street address): ______________________________________

c. Technician or medical provider performing tests (name & street address): ______________________________

d. Results of testing: ______________________________

____

C. Were you given any written instructions, warnings or other information regarding the implantation of the Guidant defibrillator and/or pacemaker?

Yes ________ No ________ I don’t know ________

1. If “yes,” when did you receive the information: ______________________

2. Who gave you the information? _________________________________

3. Do you have any of the written information in your possession? If so, please produce a copy of it together with your answers to the Plaintiff’s Fact Sheet.

Yes _______ No _______

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

____

____

D. Were you ever given any oral instructions, warnings or other information regarding your Guidant Implantable pacemaker and/or defibrillator?

Yes ________ No ________ I don’t know ________

1. If “yes,” when did you receive those instructions? ____________________

2. Who gave those instructions to you? ______________________________

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

____

____

E. If you had your Guidant implantable defibrillator and/or pacemaker explanted, please state:

1. The date of explant: ______________________

2. The reason for the explant: ______________________

3. The name and street address of the explanting surgeon: ______________________

____

____

4. Name and street address of hospital where explant was conducted: ____________

____

____

5. The present location of the explanted defibrillator and/or pacemaker: _______

____

____

6. If your explanted Guidant defibrillator and/or pacemaker has not been returned to Guidant, has it been tested?

Yes ________ No ________ I don't know ________

a. If "yes," when was it tested? ______________________

____

b. Dates of testing: ______________________

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c. Facility where testing took place (name & street address): ______________________

d. Technician or medical provider performing tests (name & street address): ______________________

e. Results of testing: ______________________

____

7. During your explant surgery, was a replacement defibrillator and/or pacemaker implanted?

Yes _______ No _______

8. If yes, state the manufacturer, make, model, lot number and serial number of the replacement defibrillator and/or pacemaker:

____

____

____

9. Did you pay for any portion of the explant surgery and the replacement defibrillator and/or pacemaker?

Yes _______ No _______

10. If not, identify all entities who paid for any part of the explant surgery and the replacement defibrillator and/or Pacemaker:

____

____

F. If you have not had your Guidant implantable defibrillator and/or Pacemaker explanted, do you presently plan to have the device explanted?

Yes _________ No _________

If yes, please provide:

1. The date scheduled for explant surgery: ______________________

____

2. The name of the explanting surgeon: ______________________________

3. The name and street address of the hospital where the explant surgery will be performed:

____

____

____

4. The reason for the explant surgery: ______________________________

Regardless of whether your device has been explanted or not, please respond to the following questions:

5. Has any doctor ever told you that you need to have your Guidant Implantable defibrillator and/or pacemaker explanted?

Yes ________ No ________

If yes, provide name and street address of each such doctor:

____

____

____

For each doctor listed, provide the date that the doctor told you that you need to have your Guidant implantable defibrillator and/or pacemaker explanted:

____

____

____

6. Has any doctor told you that your medical condition prevents you from having your Guidant Implantable defibrillator and/or pacemaker explanted?

Yes ________ No ________

If yes, provide the name and street address of each such doctor:

____

____

____

If yes, identify the medical condition: ____________________

G. If you presently have an implanted defibrillator and/or pacemaker, please state the manufacturer, make, model, lot number and serial number of that device:

____

____

V. YOUR MEDICAL HISTORY

A. Age: ______________________________

B. Height: ______________________________

C. Current weight: __________________________

D. Condition for which the Guidant defibrillator and/or pacemaker was indicated:

____

____

E. Current status of condition for which the Guidant defibrillator and/or pacemaker was implanted (e.g., improved, worsened, stable, same):

____

F. Have you had any of the following tests or procedures in the past 10 years?

Electrophysiology study: Yes _____ No _____ I don’t know _____

Cardiac Catheterization: Yes _____ No _____ I don’t know _____

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

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a. Type of test: ______________________________

b. Date administered: ______________________________

c. Reason for test: ______________________________

d. Facility name & street address: ______________________________

e. Ordering doctor: ______________________________

f. Results/diagnosis: ______________________________

(Attach additional pages, as necessary.)

VI. OTHER MEDICAL INFORMATION

A. To the best of your knowledge, have you ever been told by a doctor or any other health care provider, that you have, may have or had any of the following:

1. Hypertension or high blood pressure Yes ____ No ____

2. Heart valve problems Yes ____ No ____

3. Heart attack Yes ____ No ____

4. Stroke Yes ____ No ____

5. Any kind of blood clot Yes ____ No ____

6. Pulmonary embolism Yes ____ No ____

7. Congenital abnormality of heart Yes ____ No ____

8 Rheumatic fever Yes ____ No ____

9. Cirrhosis, hepatitis or other liver disease Yes ____ No ____

10. Alcoholism Yes ____ No ____

11. Cancer(s) Yes ____ No ____
If yes, specify type: ______________________________

12. Pulmonary hypertension Yes ____ No ____

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13.	Cardiac arrhythmias	Yes	____	No	____
14.	Endocarditis	Yes	____	No	____
15.	Any cholesterol problem	Yes	____	No	____
16.	Diabetes mellitus or other form of diabetes If yes, specify type: ______________________	Yes	____	No	____
17.	Coronary artery disease	Yes	____	No	____
18.	Other heart or lung disease If yes, specify the type: ______________________	Yes	____	No	____
19.	Gum disease, tooth infection or abscess	Yes	____	No	____
20.	Transient ischemic attack (TIA)	Yes	____	No	____
21.	Hypotension (low blood pressure)	Yes	____	No	____
22.	Carotid artery disease	Yes	____	No	____
23.	Aortic aneurysm	Yes	____	No	____
24.	Syncope, light-headness, or dizziness	Yes	____	No	____
25.	Bradycardia	Yes	____	No	____
26.	Sudden cardiac death	Yes	____	No	____
27.	Cardiomyopathy (hypertensive, ischemic)	Yes	____	No	____
28.	Tachycardia	Yes	____	No	____

B. If you responded yes to any of the above, please identify the condition, the date of onset and state the name of the physician or other individual and, if not provided elsewhere in this Fact Sheet, the street address of the physician or other individual who made the diagnosis or informed you of the condition. (Use extra pages if necessary.)

1. Condition: ____
   Onset: ____
   Name and street address of diagnosing physician or other person:
   ____

2. Condition: ______________________________
   Onset: ______________________________
   Name and street address of diagnosing physician or other person:
   ____

3. Condition: ______________________________
   Onset: ______________________________
   Name and street address of diagnosing physician or other person:
   ____

4. Condition: ______________________________
   Onset: ______________________________
   Name and street address of diagnosing physician or other person:
   ____

5. Condition: ______________________________
   Onset: ______________________________
   Name and street address of diagnosing physician or other person:
   ____

C. State the name and street address of your current family/primary care physician:

____

D. State the name and street address of each of your family/primary care physicians going back 10 years.

____

E. State the name and street address of each cardiologist, cardiac electrophysiologist, cardiac surgeon and/or thoracic surgeon that has ever seen or treated you.

____

F. State the name and street address of each hospital or surgery center where you have ever received treatment in the last 10 years.

____

G. State the name and street address of each other physician or healthcare provider from whom you ever received treatment in the last 10 years.

____

H. State the name and street address of each pharmacy, drugstore or any other facility where you ever received any prescription medication in the last ten years.

____

VII. ALLEGED INJURIES, ILLNESS AND DAMAGES

A. If you are making a claim for physical injuries or illness as a result of your Guidant defibrillator and/or pacemaker, please describe the following:

1. Nature of physical injuries or illness: ______________________________

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

____

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

____

4. Are those injuries or illness continuing? ______________________________

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

Yes _______ No _______ I don't know _______

B. Psychological injuries

1. Are you making a claim for psychological or emotional injuries as a consequence of having a Guidant implantable defibrillator and/or Pacemaker?

Yes _______ No ________

IF YOU ARE NOT MAKING A CLAIM FOR PSYCHOLOGICAL OR EMOTIONAL INJURIES, SKIP TO SECTION VIII

2. State whether you have been treated for any psychological, psychiatric or emotional problem at any time during the last ten years.

If yes, state:

1. Name and street address of each person who treated you

a. ____
Name
____
Street address (if not otherwise provided)

b. ______________________________
Name
____
Street address (if not otherwise provided)

c. ______________________________
Name
____
Street address (if not otherwise provided)

2. Condition for which treated

____

3. When treated

____

VIII. LOSS OF INCOME OR DIMINISHED EARNING CAPACITY

A. Are you making a claim for lost income or impairment of earning capacity as a result of any condition which you believe was caused by your Guidant implantable defibrillator and/or pacemaker?

Yes ____ No ____

IF YOU ARE NOT MAKING A CLAIM FOR LOSS OF INCOME, SKIP TO SECTION IX.

B. If you are making a claim for lost income, state current or last employer:

Name:

____

Street address:

____

Dates of Employment:

____

C. If you are making a claim for lost income or lost earning capacity, please provide the following information with respect to your employment for the past five (5) years.

Employers for Past Five Years	Street Address	Position	Dates of Employment

1. State the total amount of time which you have lost from work as a result of any condition which you claim or believe was caused by your Guidant implantable defibrillator and/or pacemaker:

____

2. State the total amount of income which you have lost from work as a result of any condition which you claim or believe was caused by your Guidant implantable defibrillator and/or pacemaker:

____

3. State your earned income for each of the last five years.

Year	Income
________	$ ________
________	$ ________
________	$ ________
________	$ ________
________	$ ________

IX. MEDICAL AND OUT-OF-POCKET EXPENSES

A. State the amount of medical expenses you have paid or incurred, including amounts billed or paid by insurers and other third party payors, which are related to any condition which you claim or believe was caused by your use of a Guidant implantable defibrillator and/or pacemaker for which you seek recovery in this action. $________

B. If you are making claims from out-of-pocket expenses as a result of the affected product, please complete the following:

1. What are the expenses for? ______________________________

2. Amount of fees or expenses: ______________________________

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DOCUMENT REQUEST

Attach the following documents to this declaration, to the extent that such documents are currently in your possession or your lawyers.

Please go through each Request and state whether you do or do not have anything that is responsive to the Request by checking either "Attached," "Not Applicable," or "Don't Have."

1. All press releases or other public statements made by you relating to this litigation or to your illness, injury, or medical condition that forms the basis of your Complaint.

Attached ____ Not Applicable____ Don't Have_____

2. All reports of any testing, including drafts and raw data, conducted on the Guidant implantable defibrillator and/or pacemaker that is the subject of your claim in this litigation.

Attached ____ Not Applicable____ Don't Have_____

3. All x-ray images depicting the location of the Guidant implantable defibrillator and/or pacemaker.

Attached ____ Not Applicable____ Don't Have_____

4. All documents referring or relating to your claimed damages.

Attached ____ Not Applicable____ Don't Have_____

5. Each informed consent form signed by you in connection with treatment by a health care professional and/or institution relating to any Guidant implantable defibrillator and/or pacemaker whether manufactured by Guidant or any other company.

Attached ____ Not Applicable____ Don't Have_____

6. All documents, including but not limited to, literature and/or warnings, received by you relating to any Guidant implantable defibrillator and/or pacemaker from any source.

Attached ____ Not Applicable____ Don't Have_____

7. All documents referring to or relating to your medical history over the past ten years, including, but not limited to, medical records.

Attached ____ Not Applicable____ Don't Have_____

8. All documents relating to your insurance coverage that are applicable to the illness, injury or medical condition which forms the basis of your Complaint, including any application to any insurer for coverage whether insurance was obtained or not.

Attached ____ Not Applicable____ Don't Have_____

9. All written, recorded or transcribed statements concerning this action made by any parties or witnesses, or their respective agents, servants or employees.

Attached ____ Not Applicable____ Don't Have_____

10. If you claim that you have suffered a physical injury as the result of the use of a Guidant implantable defibrillator and/or pacemaker, all documents submitted to or received from the Social Security Administration, any workers' compensation agency, or any disability insurer concerning any disability claim you have made during the past ten years.

Attached ____ Not Applicable____ Don't Have_____

11. If you are making a claim for loss of earnings or loss of earnings impairment, your state and federal tax returns for the last five years and your employment records for the last five years.

Attached ____ Not Applicable____ Don't Have_____

12. Authorizations for the release of release of medical, employment, insurance and disability records for those entities identified in this Fact Sheet.

13. If you represent a decedent's estate, provide a copy of the decedent's death certificate and autopsy report (if conducted) as well as a copy of all documents, letters, or orders appointing you as representative of the estate or otherwise reflecting your authority to act in a representative capacity.

Attached ____ Not Applicable____ Don't Have_____

DECLARATION

I declare under penalty of perjury under the laws of the United States of America that all of the information provided in this Fact Sheet is true and correct to the best of my knowledge. I further declare that I have supplied all the documents requested in the Document Request portion of this Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied authorizations for the release of medical, employment, insurance and disability records for those entities identified in these responses.

________________________________ ________________________

Signature Date

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AUTHORIZATION AND RELEASE FOR MEDICAL RECORDS

TO:

RE: **Patient Name:**
Alias/Maiden:
DOB:
SSN:

I authorize the disclosure of all protected medical information in any form to the law firms of **SHOOK, HARDY & BACON L.L.P.** located at 2555 Grand Ave., Kansas City, Mo., 64108-2613 or any members, associates or designees of the firms. I further authorize the disclosure of all protected medical information to be redisclosed to any of consultants, experts, agents, and/or other counsel hired by Shook, Hardy & Bacon. I expressly request that all covered entities under HIPPA identified above disclose full and complete protected medical information, spanning from ten years ago to the present, including but not limited to, the following:

- *All medical records, hospital records, inpatient, outpatient and emergency room treatment, all clinical charts, questionnaires/histories, reports, correspondence, test results, discharge summaries, anesthesia records, surgical consultations, social service records, questionnaires/histories, intake sheets, office notes and/or any healthcare provider's handwritten notes; and any records received from other physicians or health care providers;*

- *All autopsy, laboratory, histology, cystology, pathology, radiology, CT Scan, MRI, echocardiogram, electrocardiograms, pulmonary function tests, stress tests, angiograms, cardiac catheterization tapes, and cardiac catheterizations reports;*

- *All radiology films, x-rays, mammograms, myelograms, photographs of any type, bone scans, and any and all videos/CDs/films/reels regarding any treatment or tests performed;*

- *All medical bills, printouts, statements and/or insurance records;*

- *All pharmacy prescription records, including drug information handouts/ monographs;*

- *All documents related to amendment of any record request.*

- *All mental health records, including but not limited to, medical, psychological or other treatment, examination or counseling for any medical condition or psychological or emotional distress or upset.* This Medical Authorization specifically authorizes the production and copying of records for alcohol or drug abuse, as provided by 42 CFR § 2.1, et. seq.

I acknowledge the right to revoke this authorization by writing to a representative of Shook, Hardy & Bacon. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under *45 CFR 164.508*. I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. **Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.** This authorization expires one year from the date below.

Signature of **Patient** if 18 years of age or older: ________________________ **Date**: __________

Signature of **Parent or Legal Representative**: __________________________ **Date**: __________

Relationship to Patient, if not signed by Patient: _______________________________________