UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF LOUISIANA

In Re: TAXOTERE (DOCETAXEL) PRODUCTS LIABILITY LITIGATION

MDL NO. 2740

SECTION "N" (5)

THIS DOCUMENT RELATES TO ALL CASES

PLAINTIFF FACT SHEET

This Fact Sheet must be completed by each plaintiff who has filed a lawsuit related to the use of Taxotere® by the plaintiff or a plaintiff's decedent. 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.

In filling out this form, please use the following definitions: (1) "**healthcare provider**" means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, 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; (2) "**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.

Information provided by plaintiff will only be used for purposes related to this litigation and may be disclosed only as permitted by the protective order in this litigation. This Fact Sheet is completed pursuant to the Federal Rules of Civil Procedure governing discovery (or, for state court case, the governing rules of civil of the state in which the case is pending).

I. CASE INFORMATION

Attorney Information

Please provide the following information for the civil action that you filed:

1. Caption:_____

2. Court and Docket No.:_____

3. MDL Docket No. (if different):_____

4. Date Lawsuit Filed:_____

5. Plaintiff's Attorney:_____

6. Attorney's Address:_____
Street City State Zip Code

7. Attorney's Phone Number: ( ) -_____

8. Attorney's Email Address:_____

Plaintiff Information

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

9. Name:_____
First Name Middle Name Last Name

10. Street Address:_____

11. City:_____

12. State:_____

13. Zip code:_____

14. Date of Birth:_____

15. Place of Birth:_____

16. Social Security Number: - -_____

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

_____

18. Sex: Male: ☐ Female: ☐

19. Race:

Race	Yes
American Indian or Alaska Native	☐

Race	Yes
Asian	☐
Black or African American	☐
Native Hawaiian or Other Pacific Islander	☐
White	☐

20. Ethnicity:

Ethnicity	Yes
Hispanic or Latino	☐
Not Hispanic or Latino	☐

21. Primary Language:_____

Representative Information

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:

22. Name:_____
First Name Middle Name Last Name

23. Address:_____
Street City State Zip Code

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

25. If you were appointed as a representative by a court, identify the State, Court and Case Number:

    a) State:_____

    b) Court:_____

    c) Case Number:_____

26. Relationship to the Represented Person:_____

27. State the date of death of the decedent:_____

28. State the place of death of the decedent:_____

29. Are you filling this questionnaire out on behalf of an individual who is deceased and on whom an autopsy was performed? Yes ☐ No ☐

If you are completing this questionnaire in a representative capacity, please respond to these questions with respect to the person whose medical treatment involved Taxotere® or Docetaxel.

II. PERSONAL INFORMATION

Relationship Information

1. Are you currently: Married: ☐ Single: ☐ Engaged: ☐
   Significant other: ☐ Divorced: ☐ Widowed: ☐ Same sex partner: ☐
2. Have you ever been married? Yes ☐ No ☐
3. If yes, for EACH marriage, state the following:

Spouse's Name	Date of Marriage	Date Marriage Ended	Nature of Termination
First M.I. Last			
First M.I. Last			
First M.I. Last			
First M.I. Last			
First M.I. Last			

Education

4. For each level of education you completed, please check below:

High School: ☐ Vocational School: ☐

College: AA: ☐ BA/BS: ☐ Masters: ☐ PhD: ☐ M.D.: ☐

Other: _____

Employment

5. Are you currently employed? Yes ☐ No ☐

6. If yes, state the following:

   a) Current employer name:_____

   b) Address:_____
   Street City State Zip Code

   c) Telephone number:_____

   d) Your position there:_____

7. Are you making a claim for lost wages or lost earning capacity?
   Yes ☐ No ☐

8. Only if you are asserting a wage loss claim, please state the following for EACH employer for the last seven (7) years:

Name of Employer	Address of Employer	Dates of Employment	Annual Gross Income	Your Position
	Street City State Zip Code	to		
	Street City State Zip Code	to		
	Street City State Zip Code	to		
	Street City State Zip Code	to		

Name of Employer	Address of Employer	Dates of Employment	Annual Gross Income	Your Position
	Street City State Zip Code	to		
	Street City State Zip Code	to		
	Street City State Zip Code	to		

9. Have you ever been out of work for more than thirty (30) days for reasons related to your health in the last seven (7) years? Yes ☐ No ☐

10. If yes, please state the following:

Name of Employer	Dates	Health Reason
	to ☐ Present	
	to ☐ Present	
	to ☐ Present	

Name of Employer	Dates	Health Reason
	to ☐ Present	
	to ☐ Present	

YOU MUST ATTACH TAX RETURNS, EMPLOYMENT AUTHORIZATIONS, AND IDENTIFY THE LOSS OF CONSORTIUM PLAINTIFF'S EMPLOYERS IF CLAIMING LOST WAGES OR LOST EARNING CAPACITY DAMAGES.

Worker's Compensation and Disability Claims

11. Within the last ten (10) years, have you ever filed for workers' compensation, social security, and/or state or federal disability benefits?
    Yes ☐ No ☐

12. If yes, then as to EACH application, please state the following:

Year Claim Filed	Court	Nature of Claimed Injury	Period of Disability	Award Amount

Military Service

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

14. If yes, state the branch and dates of service:

Branch	Dates of Service
	to
	to
	to

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

16. If yes, state the condition:_____

Other Lawsuits

17. Within the last ten (10) years, have you filed a lawsuit, relating to any bodily injury, or made a claim, OTHER THAN the present suit? Yes ☐ No ☐

Computer Use

18. Apart from communications to or from your attorney, have you communicated via email, visited any chat rooms, or publicly posted a comment, message or blog entry on a public internet site regarding your experience with or injuries you attribute to Taxotere®, other chemotherapies, or alopecia/hair loss during the past ten (10) years? You should include all postings on public social network sites including Twitter, Facebook, MySpace, LinkedIn, or "blogs" that address the topics above. Yes ☐ No ☐

19. If yes, please state the following:

Forum Name	Screen Name or User Handle	Date of Post	Substance of Post

Forum Name	Screen Name or User Handle	Date of Post	Substance of Post

20. Are you now or have you ever been a member of an alopecia support group?
Yes ☐ No ☐

a) If yes, identify the group by name:_____

b) When did you join the group?_____

III. PRODUCT IDENTIFICATION

I HAVE RECORDS DEMONSTRATING USE OF TAXOTERE® OR OTHER DOCETAXEL: Yes ☐ No ☐

YOU MUST UPLOAD THEM BEFORE YOU SUBMIT THIS FACT SHEET

Taxotere®

1. Were you treated with brand name Taxotere®? Yes ☐ No ☐ Unknown ☐

Other Docetaxel

2. Were you treated with another Docetaxel or generic Taxotere®? Yes ☐ No ☐

3. If yes, select all that apply:

Name of Drug	Yes
Docetaxel – Winthrop	☐
Docetaxel – Teva Pharms USA	☐
Docetaxel – Dr. Reddy's Labs Ltd.	☐
Docetaxel – Eagle Pharms	☐
Docetaxel – Actavis Inc.	☐
Docetaxel – Pfizer Labs	☐
Docetaxel – Sandoz Inc.	☐
Docetaxel – Accord Healthcare	☐
Docetaxel – Apotex Inc.	☐
Docetaxel – Hospira Inc.	☐

Name of Drug	Yes
Docefrez – Sun Pharma Global	☐
Unknown	☐

4. **IF YOU SELECTED "UNKNOWN" YOU MUST CERTIFY AS FOLLOWS:**

   I certify that I have made reasonable, good faith efforts to identify the manufacturer of the Docetaxel used in my treatment, including requesting records from my infusion pharmacy, and the manufacturer either remains unknown at this time or I am awaiting the records: ☐

IV. MEDICAL INFORMATION

Vital Statistics

1. How old are you:_____
2. Age at the time of your alleged injury:_____
3. Current weight:_____
4. Current height:

   Feet:_____ Inches:_____

5. Weight at time of alleged injury:_____

Gynecologic and Obstetric History

6. Have you ever been pregnant? Yes ☐ No ☐

   a) Number of pregnancies:_____

   b) Number of live births:_____

7. If you have children, please state the following for EACH child:

Child's Name	Address	Date of Birth
First Name M.I. Last Name	Street City State Zip Code	

Child's Name	Address	Date of Birth
First Name M.I. Last Name	Street City State Zip Code	
First Name M.I. Last Name	Street City State Zip Code	
First Name M.I. Last Name	Street City State Zip Code	
First Name M.I. Last Name	Street City State Zip Code	
First Name M.I. Last Name	Street City State Zip Code	
First Name M.I. Last Name	Street City State Zip Code	
First Name M.I. Last Name	Street City State Zip Code	
First Name M.I. Last Name	Street City State Zip Code	
First Name M.I. Last Name	Street City State Zip Code	

8. Date of first period (menses):_____ Age:_____
9. Date of last period (menses): _____ Age:_____
10. Are you menopausal, perimenopausal or postmenopausal? Yes ☐ No ☐

11. For EACH year for the last seven (7) years before your first treatment with Taxotere® or Docetaxel and since then, who did you see for your annual gynecological exam? Also indicate whether an annual exam was skipped or missed.

Doctor	Office	Year	Skipped or Missed
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐

12. For EACH year after age 40, or before then if applicable, who did you see for your annual mammogram? Also indicate whether an annual mammogram was skipped or missed.

Doctor	Office	Year	Skipped or Missed
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐

Doctor	Office	Year	Skipped or Missed
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐

Doctor	Office	Year	Skipped or Missed
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐
First MI Last			☐

Other Risk Factors

13. Have any family members been diagnosed with breast cancer?

Family Member	Diagnosed	Age at Diagnosis
	☐	
	☐	
	☐	
	☐	
	☐	

14. Have you ever been diagnosed as having genes or gene mutations that carry an increased cancer risk (e.g., BRCA1, BRCA2)? Yes ☐ No ☐

    a) If yes, which? _____

15. Did you receive radiation treatments or exposure to radiation before the age of 30? Yes ☐ No ☐

    a) If yes, describe the particulars of your treatment or exposure:
    _____

Tobacco Use History

For the ten (10) year period before your use of Taxotere® or Docetaxel up to the present, check the answer and fill in the blanks applicable to your history of tobacco use, including cigarettes, cigars, pipes, and/or chewing tobacco/snuff.

16. I currently use tobacco: Yes ☐ No ☐

17. I have never used tobacco: Yes ☐ No ☐

18. I used tobacco in the ten (10) years before Taxotere® or Docetaxel treatment: Yes ☐ No ☐

19. Identify types of tobacco use:

Type	Used	Average Per Day	Duration of Use (Years)
Cigarettes	☐		
Cigars	☐		
Pipes	☐		
Chewing tobacco/snuff	☐		

Prescription Medications

20. Apart from chemotherapy, are there prescription or over-the-counter medications that you took on a regular basis or more than three (3) times in the seven (7) year period before you first took Taxotere®? Yes ☐ No ☐

For purposes of this question, "regular basis" means that you were directed by a healthcare provider to take a medication for at least forty-five (45) consecutive days.

21. If yes, please provide the following for EACH prescription medication:

Medication	Prescriber	Dates Taken
	First Name Last Name Street Address City State Zip Code	to ☐ Present
	First Name Last Name Street Address City State Zip Code	to ☐ Present

Medication	Prescriber	Dates Taken
	First Name Last Name Street Address City State Zip Code	to ☐ Present
	First Name Last Name Street Address City State Zip Code	to ☐ Present
	First Name Last Name Street Address City State Zip Code	to ☐ Present
	First Name Last Name Street Address City State Zip Code	to ☐ Present
	First Name Last Name Street Address City State Zip Code	to ☐ Present
	First Name Last Name Street Address City State Zip Code	to ☐ Present
	First Name Last Name Street Address City State Zip Code	to ☐ Present
	First Name Last Name Street Address City State Zip Code	to ☐ Present

Medication	Prescriber	Dates Taken
	First Name Last Name Street Address City State Zip Code	to ☐ Present
	First Name Last Name Street Address City State Zip Code	to ☐ Present
	First Name Last Name Street Address City State Zip Code	to ☐ Present
	First Name Last Name Street Address City State Zip Code	to ☐ Present
	First Name Last Name Street Address City State Zip Code	to ☐ Present
	First Name Last Name Street Address City State Zip Code	to ☐ Present
	First Name Last Name Street Address City State Zip Code	to ☐ Present
	First Name Last Name Street Address City State Zip Code	to ☐ Present

Medication	Prescriber	Dates Taken
	First Name Last Name Street Address City State Zip Code	to ☐ Present
	First Name Last Name Street Address City State Zip Code	to ☐ Present

V. CANCER DIAGNOSIS AND TREATMENT

Cancer Diagnosis & Treatment Generally

1. Have you ever been diagnosed with cancer? Yes ☐ No ☐
2. Were you diagnosed with cancer more than once? Yes ☐ No ☐
3. Did you undergo any of the following for cancer?

Treatment	Treated
Surgery	☐
Radiation	☐
Chemotherapy	☐

4. For surgery, specify:

Type of Surgery	Treated
Double mastectomy	☐
Left-side mastectomy	☐
Right-side mastectomy	☐
Lumpectomy	☐
Other:_____	☐

5. Please state the following for EACH cancer diagnosis:

Type of Cancer	
Date of Diagnosis	
Primary Oncologist	First Name Last Name Street City State Zip Code
Primary Oncologist	First Name Last Name Street City State Zip Code
Primary Oncologist	First Name Last Name Street City State Zip Code
Treatment Facility	Treatment Dates: to Treatment Facility Street City State Zip Code
Treatment Facility	Treatment Dates: to Treatment Facility Street City State Zip Code
Treatment Facility	Treatment Dates: to Treatment Facility Street City State Zip Code

Treatment Facility	Treatment Dates: to Treatment Facility Street City State Zip Code

Type of Cancer	
Date of Diagnosis	
Primary Oncologist	First Name Last Name Street City State Zip Code
Primary Oncologist	First Name Last Name Street City State Zip Code
Primary Oncologist	First Name Last Name Street City State Zip Code
Treatment Facility	Treatment Dates: to Treatment Facility Street City State Zip Code

Treatment Facility	Treatment Dates: to Treatment Facility Street City State Zip Code
Treatment Facility	Treatment Dates: to Treatment Facility Street City State Zip Code
Treatment Facility	Treatment Dates: to Treatment Facility Street City State Zip Code

Type of Cancer	
Date of Diagnosis	
Primary Oncologist	First Name Last Name Street City State Zip Code
Primary Oncologist	First Name Last Name Street City State Zip Code

Primary Oncologist	First Name Last Name Street City State Zip Code
Treatment Facility	Treatment Dates: to Name Street City State Zip Code
Treatment Facility	Treatment Dates: to Treatment Facility Street City State Zip Code
Treatment Facility	Treatment Dates: to Treatment Facility Street City State Zip Code
Treatment Facility	Treatment Dates: to Treatment Facility Street City State Zip Code

Particulars of Chemotherapy

6. When were you first diagnosed with the condition for which you were prescribed Taxotere® or Docetaxel?_____ _____

7. What was the diagnosis for which you were prescribed Taxotere® or Docetaxel?

Diagnosis	Diagnosed
Breast cancer	☐
Non-small cell lung cancer	☐
Prostate cancer	☐
Gastric adenocarcinoma	☐
Head and neck cancer	☐
Other:_____	☐

8. For breast cancer, specify:

   a) Tumor size:

Tumor Size	Yes
TX	☐
T0	☐
Tis	☐
T1	☐
T2	☐
T3	☐
T4 (T4a, T4b, T4c, T4d)	☐
Unknown	☐

   b) Metastasis:_____

   c) Node involvement:

Node	Yes
Node + NX	☐
Node + N0	☐
Node + N1	☐
Node + N2	☐

Node	Yes
Node + N3	☐
Node – (negative)	☐
Unknown	☐

d) HER2 + (positive): ☐ HER2- (negative): ☐ Unknown: ☐

e) Estrogen receptor: Positive (ER+): ☐ Negative (ER-): ☐ Unknown: ☐

f) Progesterone receptor: Positive (PR+): ☐ Negative (PR-): ☐ Unknown: ☐

9. Was Taxotere® or Docetaxel the only chemotherapy treatment that you ever received? Yes ☐ No ☐ Unknown ☐

10. Have you ever been treated with other chemotherapy drugs, either alone or in combination with or sequentially with Taxotere® or Docetaxel? Yes ☐ No ☐ Unknown ☐

11. If yes, check which of the following chemotherapy drugs you took:

Drug	Yes
5-Fluorouracil (Eludex)	☐
Actinomycin	☐
Altretamine (Hexalen)	☐
Amsacrine	☐
Bleomycin	☐
Busulfan (Busulfex, Myleran)	☐
Cabazitaxel: Mitoxantrone	☐
Carboplatin (Paraplatin)	☐
Carmustine (BiCNU, Gliadel)	☐
Cetuximab (Erbitux)	☐
Chlorambucil (Leukeran)	☐
Cisplatin (Platinol)	☐

Drug	Yes
Cyclophosphamide (Neosar)	☐
Cytarabine (Depocyt)	☐
Dacarbazine	☐
Daunorubicin (Cerubidine, DaunoXome)	☐
Doxorubicin (Adriamycin, Doxil)	☐
Epirubicin (Ellence)	☐
Erlotinib (Tarceva)	☐
Etoposide (Etopophos, Toposar)	☐
Everolimus (Afinitor, Zortress)	☐
Faslodex (Fulvestrant)	☐
Gemcitabine (Gemzar)	☐
Hexamethylmelamine (Hexalen)	☐
Hydroxyurea (Hydrea, Droxia)	☐
Idarubicin (Idamycin)	☐
Ifosfamide (Ifex)	☐
L-asparginase (crisantaspase)	☐
Lomustine (Ceenu)	☐
Melphalan (Alkeran)	☐
Mercaptopurine (Purinethol, Purixan)	☐
Methotrexate (Trexall, Rasuvo)	☐
Mitomycin	☐
Mitoxantrone	☐
Nab-paclitaxel (Abraxane): Mitoxantrone	☐
Nitrogen mustard	☐
Paclitaxel (Taxol)	☐
Panitumumab (Vectibix)	☐
Procarbazine (Matulane)	☐
Sorafenib (Nexavar)	☐

Drug	Yes
Teniposide (Vumon)	☐
Thioguanine (Tabloid)	☐
Thiotepa (Tepadina)	☐
Topotecan (Hycamtin)	☐
Vemurafenib (Zelboraf)	☐
Vinblastine	☐
Vincristine (Mariqibo, Vincasar)	☐
Vindesine	☐
Vinorelbine (Alocrest, Navelbine)	☐
Unknown	☐

12. Please provide the following information regarding Taxotere® or Docetaxel:

    a) Number of cycles: _____

    b) Frequency: Every week ☐ Every three weeks ☐
    Other:_____

    c) First treatment date:_____

    d) Last treatment date:_____

    e) Dosage:_____

        (1) Combined with another chemotherapy drug: ☐

        (2) Sequential with another chemotherapy drug: ☐

        (3) If so, describe the combination or sequence:_____

13. Prescribing Physician(s):

Prescribing Physician	Address
First Name M.I. Last Name	Street City State Zip Code

Prescribing Physician	Address
First Name M.I. Last Name	Street City State Zip Code
First Name M.I. Last Name	Street City State Zip Code
First Name M.I. Last Name	Street City State Zip Code
First Name M.I. Last Name	Street City State Zip Code

14. Treatment Facility:

Treatment Facility	Address
	Street City State Zip Code
	Street City State Zip Code
	Street City State Zip Code
	Street City State Zip Code
	Street City State Zip Code

15. Identify EACH state where you resided when you began and while taking Taxotere® or Docetaxel:

State	From Date	To Date

16. Was your Taxotere® or Docetaxel treatment part of a clinical trial? Yes ☐ No ☐ Unknown ☐

17. If yes, please provide the name and location of the trial site:

    a) Name of trial site:_____

    b) Location of trial site:_____

VI. CLAIM INFORMATION

Current Status

1. Are you currently taking Taxotere® or Docetaxel? Yes ☐ No ☐
2. Are you currently cancer-free? Yes ☐ No ☐
3. If no, check those that apply to your CURRENT status:

Current Status	Yes
In remission	☐
Currently receiving chemotherapy	☐
Currently receiving radiation therapy	☐
Currently hospitalized for cancer or cancer-related complications	☐
Currently in home health or hospice care for cancer or cancer-related complications	☐
Cancer returned after taking Taxotere® or Docetaxel	☐

4. When was the last (most recent) date you consulted with an oncologist:_____

Alleged Injury

5. State the injury you allege in this lawsuit and the dates between which you experienced the alleged injury. Check all that apply:

Alleged Injury	Yes	No	From	To
Persistent total alopecia – No hair growth on your head or body after six (6) months of discontinuing Taxotere® or Docetaxel treatment	☐	☐		
Persistent alopecia of your head – No hair growth on your head after six (6) months of discontinuing Taxotere® or Docetaxel treatment. Hair is present elsewhere on your body	☐	☐		
Permanent/Persistent Hair Loss on Scalp	☐	☐		
Diffuse thinning of hair: partial scalp ☐ Top ☐ Sides ☐ Back ☐ Temples ☐ Other:_____	☐	☐		
Diffuse thinning of hair: total scalp ☐ Top ☐ Sides ☐ Back ☐ Temples ☐ Other:_____	☐	☐		
Significant thinning of the hair on your head after six (6) months of discontinuing Taxotere® or Docetaxel treatment – There are visible bald spots on your head no matter how you style your hair	☐	☐		
Moderate thinning of the hair on your head after six (6) months of discontinuing Taxotere® or Docetaxel treatment – There is noticeable hair loss but if you brush or style your hair, the hair loss is less evident	☐	☐		
Small bald area in the hair on your head	☐	☐		
Large bald area in the hair on your head	☐	☐		
Multiple bald spots in the hair on your head	☐	☐		
Change in the texture, thickness or color of your hair after Taxotere® or Docetaxel treatment	☐	☐		

Alleged Injury	Yes	No	From	To
Other:_____	☐	☐		
Permanent/Persistent Loss of Eyebrows	☐	☐		
Permanent/Persistent Loss of Eyelashes	☐	☐		
Permanent/Persistent Loss of Body Hair	☐	☐		
Permanent/Persistent Loss of Genital Hair	☐	☐		
Permanent/Persistent Loss of Nasal Hair	☐	☐		
Permanent/Persistent Loss of Ear Hair	☐	☐		
Permanent/Persistent Loss of Hair in Other Areas Describe:_____	☐	☐		

6. Have you ever received treatment for the injury you allege in this lawsuit?
   Yes ☐ No ☐

Name of Treating Physician	Dates of Treatment	Treatments
First Name M.I. Last Name	to ☐ Present	
First Name M.I. Last Name	to ☐ Present	
First Name M.I. Last Name	to ☐ Present	

Name of Treating Physician	Dates of Treatment	Treatments
First Name M.I. Last Name	to ☐ Present	
First Name M.I. Last Name	to ☐ Present	

7. Were you diagnosed by a healthcare provider for the injury you allege in this lawsuit? Yes ☐ No ☐

Name of Diagnosing Physician	Dates of Treatment	Treatments
First Name M.I. Last Name	to ☐ Present	
First Name M.I. Last Name	to ☐ Present	
First Name M.I. Last Name	to ☐	
First Name M.I. Last Name	to ☐ Present	
First Name M.I. Last Name	to ☐ Present	

8. Have you discussed with any healthcare provider whether Taxotere® or Docetaxel caused or contributed to your alleged injury? Yes ☐ No ☐

Name of Physician	Dates of Treatment	Treatments
First Name M.I. Last Name	to ☐ Present	
First Name M.I. Last Name	to ☐ Present	
First Name M.I. Last Name	to ☐ Present	
First Name M.I. Last Name	to ☐ Present	
First Name M.I. Last Name	to ☐ Present	

Statement Information

9. Were you ever given any written instructions, including any prescriptions, packaging, package inserts, literature, medication guides, or dosing instructions, regarding chemotherapy, Taxotere® or Docetaxel? Yes ☐ No ☐

10. If yes, please describe the documents, if you no longer have them. If you have the documents, please produce them:

Description of Document	I Have the Documents	I Do Not Have the Documents
	☐	☐
	☐	☐

Description of Document	I Have the Documents	I Do Not Have the Documents
	☐	☐
	☐	☐
	☐	☐

11. Were you given any oral instructions from a healthcare provider regarding chemotherapy or your use of Taxotere® or Docetaxel? Yes ☐ No ☐

12. If yes, please identify each healthcare provider who provided the oral instructions:

Name of Healthcare Provider		
First Name	Last Name	M.I.
First Name	Last Name	M.I.
First Name	Last Name	M.I.
First Name	Last Name	M.I.
First Name	Last Name	M.I.

13. Have you ever seen any advertisements (e.g., in magazines or television commercials) for Taxotere® or Docetaxel? Yes ☐ No ☐

14. If yes, identify the advertisement or commercial, and approximately when you saw the advertisement or commercial:

Type of Advertisement or Commercial	Date of Advertisement or Commercial

15. Other than through your attorneys, have you had any communication, oral or written, with any of the Defendants or their representatives? Yes ☐ No ☐

16. If yes, please identify:

Date of Communication	Method of Communication	Name of Representative	Substance of Communication
		First Name Last Name	
		First Name Last Name	
		First Name Last Name	
		First Name Last Name	
		First Name Last Name	

17. Have you filed a MedWatch Adverse Event Report to the FDA? Yes ☐ No ☐

YOU MUST UPLOAD NOW ANY MEDICAL RECORDS IN YOUR POSSESSION DEMONSTRATING ALLEGED INJURY OR PHOTOGRAPHS SHOWING YOUR HAIR BEFORE AND AFTER TREATMENT WITH TAXOTERE® ALONG WITH THE DATE(S) THE PHOTOGRAPHS WERE TAKEN.

Other Claimed Damages

18. Mental or Emotional Damages: Do you claim that your use of Taxotere® or Docetaxel caused or aggravated any psychiatric or psychological condition? Yes ☐ No ☐

19. If yes, did you seek treatment for the psychiatric or psychological condition? Yes ☐ No ☐

Provider	Date	Condition
First Name Last Name M.I.		
First Name Last Name M.I.		
First Name Last Name M.I.		
First Name Last Name M.I.		

Provider	Date	Condition
First Name Last Name M.I.		

20. Medical Expenses: Do you claim that you incurred medical expenses for the alleged injury that you claim was caused by Taxotere® or Docetaxel? Yes ☐ No ☐

21. If yes, list all of your medical expenses, including amounts billed or paid by insurers and other third-party payors, which are related to any alleged injury you claim was caused by Taxotere® or Docetaxel:

Provider	Date	Expense
First Name Last Name M.I.		
First Name Last Name M.I.		
First Name Last Name M.I.		
First Name Last Name M.I.		
First Name Last Name M.I.		
First Name Last Name M.I.		
First Name Last Name M.I.		
First Name Last Name M.I.		
First Name Last Name M.I.		
First Name Last Name M.I.		

22. Lost Wages: Do you claim that you lost wages or suffered impairment of earning capacity because of the alleged injury that you claim was caused by Taxotere® or Docetaxel? Yes ☐ No ☐

23. If yes, state the annual gross income you earned for each of the three (3) years before the injury you claim was caused by Taxotere® or Docetaxel.

Year	Annual Gross Income

24. State the annual gross income for every year following the injury or condition you claim was caused by Taxotere® or Docetaxel.

Year	Annual Gross Income

25. Out-of-Pocket Expenses: Are you making a claim for lost out-of-pocket expenses? Yes ☐ No ☐

26. If yes, please identify and itemize all out-of-pocket expenses you have incurred:

Expense	Expense Amount

Expense	Expense Amount

VII. HAIR LOSS INFORMATION

Background

1. Did you ever see a healthcare provider for hair loss BEFORE taking Taxotere® or Docetaxel? Yes ☐ No ☐
2. Did your hair loss begin during chemotherapy treatment? Yes ☐ No ☐
3. If yes, did you FIRST experience hair loss:
   a) After treatment with another chemotherapy agent: ☐
   b) After treatment with Taxotere® or Docetaxel: ☐
4. At any time before or during the hair loss were you:

Condition	Yes	Description
Pregnant	☐	
Seriously ill	☐	
Hospitalized	☐	
Under severe stress	☐	
Undergoing treatment for any other medical condition	☐	

5. When did you FIRST discuss with or see a healthcare provider about your hair loss? _____
   Month Day Year
6. Have you started any special diets at any time before or during the hair loss? Yes ☐ No ☐ Describe:_____

Hair Loss History

Question	No	Yes	Name of Healthcare Provider
Have you had a biopsy of your scalp to evaluate your hair loss problem?	☐	☐	First Name Last Name M.I.
Have you had blood tests done to evaluate your hair loss problem?	☐	☐	First Name Last Name M.I.
Have your hormones ever been checked to evaluate your hair loss problem?	☐	☐	First Name Last Name M.I.
Have you ever been told by a doctor that you have a thyroid condition?	☐	☐	First Name Last Name M.I.
Have you ever been treated with thyroid hormone?	☐	☐	First Name Last Name M.I.
Have you ever been told by a doctor that you have a low iron level?	☐	☐	First Name Last Name M.I.

7. Have you ever been on endocrine or hormonal therapy, either before or after chemotherapy with Taxotere® or Docetaxel? Yes ☐ No ☐

If yes, please identify:

Treating Physician	Dates of Treatment	Treatment
First Name M.I. Last Name	to ☐ Present	
First Name M.I. Last Name	to ☐ Present	
First Name M.I. Last Name	to ☐ Present	
First Name M.I. Last Name	to ☐ Present	

Treating Physician	Dates of Treatment	Treatment
First Name M.I. Last Name	to ☐ Present	

8. Do you have any autoimmune diseases? Yes ☐ No ☐

9. If yes, check the following which describes you:

Autoimmune Disease	Yes
Lupus	☐
Rheumatoid arthritis	☐
Celiac disease	☐
Type 1 diabetes	☐
Sjogrens disease	☐
Vitiligo	☐
Hashimoto's	☐
Other:_____	☐

10. Were you taking any medications when your hair loss began? Yes ☐ No ☐

Medication

Medication

Hair Care

11. How often do you wash/shampoo your hair? Every _____ days

12. Check any of the following that apply to you currently or that have in the past:

Hair Treatment	Yes	Period of Time	Frequency
Hair chemically processed or straightened (relaxers, keratin, Brazilian blowout, Japanese straightening, other)	☐	☐ Present	
Hair heat processed or straightened (blow drying/ flat ironing, curling)	☐	☐ Present	
Hair dyed	☐	☐ Present	
Hair highlighted	☐	☐ Present	
Braids	☐	☐ Present	
Weaves	☐	☐ Present	
Tight hairstyles (ponytails)	☐	☐ Present	

Hair Treatment	Yes	Period of Time	Frequency
Extensions	☐	☐ Present	
Other:_____	☐	☐ Present	

13. Have you ever used the following?

Hair Treatment	Yes
WEN Cleansing Conditioners	☐
Unilever Suave Professionals Keratin Infusion	☐
L'Oréal Chemical Relaxer	☐

14. Has your hair care regimen been different in the past? Yes ☐ No ☐

    a) If yes, describe:_____

Hair Loss Treatment

15. Did you use any other methods to prevent hair loss during chemotherapy?

Hair Treatment	Yes
Folic Acid supplementation	☐
Minoxidil	☐
Other:_____	☐

16. Did you wear a cool cap during chemotherapy treatment? Yes ☐ No ☐

17. If yes, which cooling cap did you wear: _____

18. Have you used any over-the-counter medications, supplements, or cosmetic aides for your hair loss? Yes ☐ No ☐

19. If yes, please state the following:

Treatment	When was it tried?	How long did you try it?	Did it help?

Treatment	When was it tried?	How long did you try it?	Did it help?

20. Has anything helped your hair loss? Yes ☐ No ☐

21. If yes, please specify:

Type of Product	Dates of Use	Place of Purchase	Results of Use
	to ☐ Present		
	to ☐ Present		
	to ☐ Present		
	to ☐ Present		
	to ☐ Present		

Type of Product	Dates of Use	Place of Purchase	Results of Use
	to ☐ Present		

22. As of the date you verify your PFS, how long have you had alopecia or incomplete hair re-growth?_____

23. Has any hair regrowth occurred? Yes ☐ No ☐

24. Have you ever worn a wig to conceal your hair loss? Yes ☐ No ☐

25. Specify:

Dates Used	Period of Use	Place Purchased	Cost of Item
to ☐ Present			
to ☐ Present			
to ☐ Present			
to ☐ Present			
to ☐ Present			

Dates Used	Period of Use	Place Purchased	Cost of Item
to ☐ Present			

VIII. RECORD HOLDER IDENTIFICATION

Healthcare Providers:

1. Identify each physician, doctor, or other healthcare provider who has provided treatment to you for any reason in the past eight (8) years and the reason for consulting the healthcare provider or mental healthcare provider.

YOU MUST INCLUDE YOUR ONCOLOGIST, RADIOLOGIST, DERMATOLOGIST, DERMATOLOGIST-PATHOLOGIST, HAIR LOSS SPECIALIST, GYNECOLOGIST, OBSTETRICIAN, AND PRIMARY CARE PHYSICIAN, ALONG WITH ANY OTHER HEALTHCARE PROVIDERS IDENTIFIED ABOVE

Name	Area or Specialty	Address	Dates	Reason for Consultation
First Name M.I. Last Name		Street City State Zip Code	to ☐ Present	
First Name M.I. Last Name		Street City State Zip Code	to ☐ Present	
First Name M.I. Last Name		Street City State Zip Code	to ☐ Present	
First Name M.I. Last Name		Street City State Zip Code	to ☐ Present	

Name	Area or Specialty	Address	Dates	Reason for Consultation
First Name M.I. Last Name		Street City State Zip Code	to ☐ Present	
First Name M.I. Last Name		Street City State Zip Code	to ☐ Present	
First Name M.I. Last Name		Street City State Zip Code	to ☐ Present	
First Name M.I. Last Name		Street City State Zip Code	to ☐ Present	
First Name M.I. Last Name		Street City State Zip Code	to ☐ Present	
First Name M.I. Last Name		Street City State Zip Code	to ☐ Present	

Hospitals, Clinics, and Other Facilities:

2. Identify each hospital, clinic, surgery center, physical therapy or rehabilitation center, or other healthcare facility where you have received inpatient or outpatient treatment (including emergency room treatment) in the past eight (8) years:

YOU MUST INCLUDE THE LOCATIONS FOR SURGERIES, RADIOLOGY, IMAGING, BIOPSIES, CHEMOTHERAPY, CHILD BIRTHS, GYNECOLOGIC PROCEDURES OR TREATMENT, ALONG WITH ANY OTHER HEALTHCARE FACILITIES

Name	Address	Dates	Reason for Treatment
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	

Name	Address	Dates	Reason for Treatment
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	

Laboratories:

3. Identify each laboratory at which you had tests run in the past ten (10) years:

Name	Address	Dates	Test	Reason for Tests
	Street City State Zip Code	to ☐ Present		
	Street City State Zip Code	to ☐ Present		
	Street City State Zip Code	to ☐ Present		
	Street City State Zip Code	to ☐ Present		
	Street City State Zip Code	to ☐ Present		

Name	Address	Dates	Test	Reason for Tests
	Street City State Zip Code	to ☐ Present		
	Street City State Zip Code	to ☐ Present		
	Street City State Zip Code	to ☐ Present		
	Street City State Zip Code	to ☐ Present		
	Street City State Zip Code	to ☐ Present		

Pharmacies:

4. To the best of your recollection, Identify each pharmacy, drugstore, and/or other supplier (including mail order) where you have had prescriptions filled or from which you have ever received any prescription medication within three (3) years prior to and three (3) years after your first treatment with Taxotere:

Name	Address	Dates	Medications
	Street City State Zip Code	to ☐ Present	

Name	Address	Dates	Medications
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	

Name	Address	Dates	Medications
	Street City State Zip Code	to ☐ Present	

Retailers:

5. Identify each pharmacy, drugstore, and/or other retailer (including mail order) where you have purchased over-the-counter medications, or hair products in the past ten (10) years:

Name	Address	Dates	Purchases
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	

Name	Address	Dates	Purchases
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	
	Street City State Zip Code	to ☐ Present	

Insurance Carriers:

6. Identify each health insurance carrier which provided you with medical coverage and/or pharmacy benefits for the last ten (10) years:

Carrier	Address	Name of Insured & SSN	Policy Number	Dates of Coverage
	Street City State Zip Code	First Name M.I. Last Name SSN:		to ☐ Present
	Street City State Zip Code	First Name M.I. Last Name SSN:		to ☐ Present
	Street City State Zip Code	First Name M.I. Last Name SSN:		to ☐ Present

Carrier	Address	Name of Insured & SSN	Policy Number	Dates of Coverage
	Street City State Zip Code	First Name M.I. Last Name SSN:		to ☐ Present
	Street City State Zip Code	First Name M.I. Last Name SSN:		to ☐ Present
	Street City State Zip Code	First Name M.I. Last Name SSN:		to ☐ Present

IX. DOCUMENT REQUESTS AND AUTHORIZATIONS

Please state which of the following documents you have in your possession. If you do not have the following documents but know they exist in the possession of others, state who has possession of the documents: Produce all documents in your possession (including writings on paper or in electronic form) and signed authorizations and attach a copy of them to this PFS.

Requests

Type of Document(s)	Yes	No	If No, who has the document(s)?
Documents you reviewed to prepare your answers to this Plaintiff Fact Sheet. *Your attorney may withhold some documents on claims of attorney-client privilege or work product protection and, if so, provide a privilege log*	☐	☐	
Medical records or other documents related to the use of Taxotere® or Docetaxel at any time for the past twelve (12) years.	☐	☐	
Medical records or other documents related to your treatment for any disease, condition or symptom referenced above for any time in the past twelve (12) years.	☐	☐	
Laboratory reports and results of blood tests performed on you related to your hair loss.	☐	☐	

Type of Document(s)	Yes	No	If No, who has the document(s)?
Pathology reports and results of biopsies performed on you related to your hair loss. *Plaintiffs or their counsel must maintain the slides and/or specimens requested in this subpart, or send a preservation notice, copying Defendants, to the healthcare facility where these items are maintained.*	☐	☐	
Documents reflecting your use of any prescription drug or medication at any time within the past eight (8) years.	☐	☐	
Documents identifying all chemotherapy agents that you have taken.	☐	☐	
Documents for any workers' compensation, social security or other disability proceeding at any time within the last five (5) years.	☐	☐	
Instructions, product warnings, package inserts, handouts or other materials that you were provided or obtained in connection with your use of Taxotere®.	☐	☐	
Advertisements or promotions for Taxotere®.	☐	☐	
Articles discussing Taxotere®.	☐	☐	
Any packaging, container, box, or label for Taxotere® or Docetaxel that you were provided or obtained in connection with your use of Taxotere®. *Plaintiffs or their counsel must maintain the originals of these items.*	☐	☐	
Documents which mention Taxotere® or Docetaxel or any alleged health risks related to Taxotere®. *Your attorney may withhold some legal documents, documents provided by your attorney, or documents obtained or created for the purpose of seeking legal advice or assistance on claims of attorney-client privilege or work product protection and, if so, provide a privilege log.*	☐	☐	
Documents obtained directly or indirectly from any of the Defendants.	☐	☐	
Communications or correspondence between you and any representative of the Defendants.	☐	☐	
Photographs, drawing, slides, videos, recordings, DVDs, or any other media that show your alleged injury or its effect in your life.	☐	☐	

Type of Document(s)	Yes	No	If No, who has the document(s)?
Journals or diaries related to the use of Taxotere® or Docetaxel or your treatment for any disease, condition or symptom referenced above at any time for the past twelve (12) years.	☐	☐	
Social media or internet posts to or through any site (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 Taxotere® or Docetaxel or any of your claims in this lawsuit.	☐	☐	
If you claim you have suffered a loss of earnings or earning capacity, your federal tax returns for each of the five (5) years preceding the injury you allege to be caused by Taxotere® or Docetaxel, and every year thereafter or W-2s for each of the five (5) years preceding the injury you allege to be caused by Taxotere® or Docetaxel, and every year thereafter.	☐	☐	
If you claim any medical expenses, bills from any physician, hospital, pharmacy or other healthcare providers.	☐	☐	
Records of any other expenses allegedly incurred as a result of your alleged injury.	☐	☐	
If you are suing in a representative capacity, letters testamentary or letters of administration.	☐	☐	
If you are suing in a representative capacity on behalf of a deceased person, decedent's death certificate and/or autopsy report.	☐	☐	
Photographs of you that are representative of your hair composition before treatment with Taxotere® or Docetaxel.	☐	☐	
Photographs of you that are representative of your hair composition during treatment with Taxotere® or Docetaxel.	☐	☐	
Photographs of you that are representative of your hair composition six months after conclusion of treatment with Taxotere® or Docetaxel.	☐	☐	
Photographs of you that are representative of your hair composition in present day.	☐	☐	

Type of Document(s)	Yes	No	If No, who has the document(s)?
Signed authorizations for medical records related to any cancer treatment identified herein and all pharmacy records from three (3) years before and three (3) years after your first treatment with Taxotere in the forms attached hereto.	☐	☐	

X. DECLARATION

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that all of the information provided in connection with this Plaintiff Profile Form is true and correct to the best of my knowledge information and belief at the present time.

_____ _____

Signature Date

XI. AUTHORIZATIONS