Talc Powder Questionnaire

Date: _____

PART I – Background Information: Client Information

Name: _____

Spouse's Name: _____

Street Address: _____

City/State/Zip: _____ County: _____

Home Phone: _____ Work/Cell Phone: _____

Personal E-Mail address: _____

DOB: _____ SSN: _____

Alternate Contact Person (outside the home)
IMPORTANT INFORMATION MUST BE FILLED IN

Name: _____ Home Phone: _____
Address: _____ Work phone: _____
_____ E-Mail address: _____

Decedent Information

Name of deceased: _____ **DATE OF DEATH:** _____

Decedent's DOB: _____ Decedent's SSN: _____

State where person died: _____

Did the death occur in the person's resident state? _____

If not, what were the circumstances surrounding the decedent being in another state? _____

_____

Was autopsy performed? _____ (If yes, please provide copy of the autopsy report)

Cause of death: _____

(Please provide copy of death certificate)

Did decedent have a will?_____ Has an estate been opened? _____

Estate attorney name and phone number: _____

PART II – Talc Powder Information (please complete on behalf of injured party):

Did you use talc powder in your genital area? □ Yes □ No

What state(s) did you live in during the time you used talc product? _____

Did you or your loved one use Johnson & Johnson Baby Powder? □ Yes □ No

Did you or your loved one use Shower to Shower? □ Yes □ No

What are the name(s) of any additional talc powder products you used? _____

_____

Are you still using talc powder products in the genital area? _____

Date started using? ____/____/____ Month / Date / Year **Date stopped using?** ____/____/____ Month / D ate / Year

If completing on behalf of deceased,

How do you know talcum powder was applied in the genital area? _____

_____

_____

Are there any living eye witnesses who can testify regarding use? □ Yes □ No

If yes, whom (name and relation)? _____

_____

PART III - Injury Information (please complete on behalf of injured party):

Have you been diagnosed with ovarian cancer? □ Yes □ No

Date Diagnosed? _____/_____/_____
Month / D ate / Year

What state did you live in at time of diagnosis? _____

What type ovarian cancer? _____ What stage cancer? _____

Please list the physician that diagnosed you:

Name: _____

Address: _____

Phone Number: _____

Please list the hospital you were admitted to, if applicable, when you were diagnosed: _____

_____

_____

Are you currently in remission? □ Yes □ No

If no, please explain: _____

Have you been treated by a doctor or been hospitalized as result of your talc powder-related injuries? □ Yes □ No

Please provide the doctor's name and address (please list all surgeons, oncologists, radiologists or any other doctor or hospital in which you have been treated for ovarian cancer):

Did you receive chemotherapy treatments: □ Yes □ No When: _____

Name of physician: _____

Address: _____

Phone Number: _____

Did you receive radiation treatments: □ Yes □ No When: _____

Name of physician: _____

Address: _____

Phone Number: _____

Did you receive drug therapy treatments: □ Yes □ No When: _____

Name of physician: _____

Address: _____

Phone Number: _____

Did you have surgery: □ Yes □ No When: _____

What Surgery: _____

Name of physician: _____

Address: _____

Phone Number: _____

Name of facility where surgery was performed:

Address: _____

Phone Number: _____

Were your ovaries and/or fallopian tubes removed? □ Yes □ No

Please list any other physicians or facilities that you or your loved one received treatment at for ovarian cancer below:

Name: _____

Address: _____

Phone Number: _____

Reason for consult: _____

Name: _____

Address: _____

Phone Number: _____

Reason for consult: _____

Name: _____

Address: _____

Phone Number: _____

Reason for consult: _____

What additional injury(ies) did you suffer as a result of using talc powder product(s)? _____

_____

When were you diagnosed? _____

How did you first become aware that your ovarian cancer may have been caused by using talc powder? _____

Date: ____/____/____
Month / D ate / Year

Part IV – History Information (please complete on behalf of injured party):

Do you smoke? _____

If YES, how much per day and what: _____

Have you smoked in the past? _____ If YES, when did you quit: _____

If YES, how much per day and what: _____

Do you or have you used any illicit/street drugs? _____

If YES, please list: _____

Have you been diagnosed with cancer before your ovarian cancer diagnosis? □ Yes □ No

If yes, what type cancer and date of diagnosis: _____

Do you have a family history of cancer? □ Yes □ No

If yes, please list relation to you, type of cancer, and date of diagnosis and/or death (to include biological parents, grandparents, siblings, children, aunts, uncles, and first cousins – and identify as maternal (mothers' side) and/or paternal (father's side)):

Relation	Type of Cancer	Date of Diagnosis	Date of Death
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you been pregnant? □ Yes □ No How many children? _____

Have you ever used or are you currently taking birth control pills? □ Yes □ No

If yes, please list name and/or type of birth control taken, dates of use and doctor who prescribed: ____

_____

Have you ever used any type of fertility medication? □ Yes □ No

If yes, please list name and/or type of fertility medications taken, dates of use and doctor who prescribed:

_____

_____

Have you had a tubal ligation? □ Yes □ No If yes, when? ____/____/____

Month / Date / Year

Did you experience menopause before your ovarian cancer diagnosis? □ Yes □ No

Have you ever used any hormone replacement therapy? □ Yes □ No

Date started using? ____/____/____ Date stopped using? ____/____/____

Month / Date / Year Month / Date / Year

Please list the name of the hormone replacement therapy product(s) used: _____

_____

Have you ever been diagnosed with endometriosis? □ Yes □ No If yes, when? ____/____/____

Month / Date / Year

If yes, please list any treatment: _____

Have you undergone genetic testing for pre-disposition to ovarian cancer? □ Yes □ No

If yes, which tests were performed and what were the results: _____

_____

What was your height and weight at the time of the ovarian cancer diagnosis?

Weight: _____ Height: _____

Are you of Ashkenazi Jewish descent? □ Yes □ No

Part V – Other Information (please complete on behalf of injured party):

Do you have health insurance? _____

Insurance provider name: _____

Have you ever filed bankruptcy? _____

Date of bankruptcy: _____

Type of bankruptcy filed: _____

Date of discharge: _____

Is bankruptcy pending? _____

Who is your bankruptcy attorney? _____

Address and phone number: _____

Do you receive Social Security benefits? _____

Do you receive Medicaid benefits? _____

Do you receive Medicare benefits? _____

Do you receive any type of public assistance? _____

Do you receive VA benefits? _____

Please identify each social networking website (for example, but not limited to, MySpace, Facebook, LiveJournal, Match.com), personal web page, internet bulletin board, internet user group, internet support group, and internet list serve on which you have posted or in which your participate: _____

_____

_____

_____

_____