VAGINAL / TRANSVAGINAL MESH QUESTIONNAIRE

To speed our evaluation of your injury, please provide as much information as possible.
If you need more space to answer a question, please use extra paper (remember to number your answers).

BOX 1: INJURED PERSON'S INFORMATION

1.a. INJURED PERSON'S FULL NAME: _____ **DOB:** _____ **SSN:** _____

1.b. Injured Person's Address (include street address for PO Boxes):
_____
_____
_____
_____
COUNTY: _____

1.c. Injured Person's Telephone Numbers:
Home ( ) - Cell ( ) -
Work ( ) - Fax ( ) -
E-mail: _____

1.d. Spouse's Name (if applicable): First Name:_____ Last Name: _____

1.e. Telephone numbers of 3 people or places of business which will always know the Injured Person's whereabouts:
1. Name _____ Relationship _____ Phone #1 ( ) - Phone #2 ( ) -
2. Name _____ Relationship _____ Phone #1 ( ) - Phone #2 ( ) -
3. Name _____ Relationship _____ Phone #1 ( ) - Phone #2 ( ) -

1.f. Are you completing this form for Yourself or Someone Else? ☐ Myself *(skip to Box 3, below)* ☐ Someone Else *(go to Box 2)*

BOX 2: PERSON COMPLETING THIS FORM

2.a. Is the person completing this form the Injured Person?
☐ Yes *(If Yes, skip to Box 3, below)*
☐ No, I am completing this form on the Injured Person's behalf
Your name:_____

2.b. If you are completing this form on the Injured Person's behalf, what is your relationship to the Injured Person?
The Injured person is my: _____

2.c. If you are completing this form for the Injured Person, your Address (include street address for PO Boxes):
_____
_____
_____
_____

2.d. If you are completing this form for the Injured Person:
Your Telephone: Home ( ) -
Work ( ) -
Mobile ( ) -
Fax ( ) -
Your E-mail: _____

2.e. Is the Injured Person: ☐ Too sick to complete paperwork ☐ Other: _____

☐ Deceased - If so, Date of Death: _____ IF DECEASED - PLEASE SEND A COPY OF THE DEATH CERTIFICATE WITH THIS QUESTIONNAIRE AND ANY LEGAL DOCUMENTS NOTING THAT YOU HAVE AUTHORITY TO ACT ON THE BEHALF OF THIS PERSON'S ESTATE

NOTE: FOR THE REST OF THIS QUESTIONNAIRE, THE WORDS "YOU" AND "YOUR" REFER TO THE INJURED PERSON. If you are filling out this form on behalf of someone else, from this point on pleasefill it out from the Injured Person's perspective.

BOX 3: SURGERY

3.a. Do you know which brand of vaginal mesh you have implanted in your body: ____ Yes _____ No .

If yes, please list the manufacturer / model / lot number of your implanted mesh:_____

Do you have an implant card which identifies the type of mesh you have: _____ Yes ____ No. **IF YES, INCLUDE A COPY OF CARD.**

3.b. Date of the surgical procedure during which you received the mesh: _____

3.c. Type of Surgical Procedure which the mesh was used to repair: ____ Urinary Incontinence _____ Organ Prolapse ____ Rectocele Repair ______Other - if Other - give name of surgery: ____

3.d. Name of Hospital (where implanted): ____
Address of Hospital:____
Telephone Number of Hospital: ____

3.e. Name of Surgeon (that implanted): ____
Address of Surgeon: ____
Telephone Number of Surgeon:____________________________________

3.f. Has the mesh been removed: _____Yes _____ No. If Yes, date:____________ and who removed (Surgeon): ___________________
Hospital where removed (Address, City, State): ____
If removed - please give the reason that it was removed: ____
List problems you had that led to the mesh being removed:____

3.g. Has the mesh been replaced with another mesh: _____ Yes _____ No. If yes, date: _________and who replaced: ______________

BOX 4: INJURIES

4.a. What have you experienced following the surgery to remove the mesh or when it was being removed? Check all that apply.

- ☐ Additional Surgery to Remove / Repair / Replace Mesh: *Date(s):* ________________________
- ☐ Surgery to Repair a Bladder Perforation: *Date(s):* ________________________
- ☐ Vaginal Surgery Repair (Erosion of Mesh): *Date(s):*________________________
- ☐ Infection and site of infection:________________ *Date(s):* ________________________
- ☐ Death *Date(s):* ________________________
- ☐ Other: Describe: ____________________________ *Date(s):* ________________________

4.b. For each Medical Event you marked, please provide the Names/Addresses/Facilities of the doctors who diagnosed you.

Medical Event: __________________ Date: ______________
Doctor: ____
Was this an emergency room doctor? ☐Yes ☐No
Doctor's Address (including hospital or clinic name, if applicable):
____
____
____
____

Medical Event: __________________ Date: ______________
Doctor: ____
Was this an emergency room doctor? ☐Yes ☐No
Doctor's Address (including hospital or clinic name, if applicable):
____
____
____
____

Medical Event: __________________ Date: ______________
Doctor: ____
Was this an emergency room doctor? ☐Yes ☐No
Doctor's Address (including hospital or clinic name, if applicable):
____
____
____
____

Medical Event: __________________ Date: ______________
Doctor: ____
Was this an emergency room doctor? ☐Yes ☐No
Doctor's Address (including hospital or clinic name, if applicable):
____
____
____
____

BOX 5: PHYSICIANS MONITORING YOUR CONDITION NOW

Names/Addresses of all doctors who are following you for the Medical Events you marked in prior section:

Doctor's Name: _____
Specialty: _____
Treatment Period: From _____ To _____
Address (including name of clinic or hospital, if applicable):

_____
_____
_____
_____

Doctor's Name: _____
Specialty: _____
Treatment Period: From _____ To _____
Address (including name of clinic or hospital, if applicable):

_____
_____
_____
_____

BOX 6: ADDITIONAL INFORMATION

6.a. Are you now, or have you ever been represented by an attorney for this claim? ☐ Yes ☐ No
If yes, attorney's name: _____ Law Firm: _____

6.b. Is there anything we did not ask that you think we should know? ☐ Yes ☐ No
If Yes, what:

END OF QUESTIONNAIRE - THANKS FOR YOUR ASSISTANCE!