PRADAXA 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

NAME: _____ **Date of Birth:** _____ **Social Security Number:** _____

Injured Person's Address (include street address for PO Boxes):
_____
_____
_____
_____

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

If you have not lived at your present address for the past ten years - please list the city and state of addresses you have resided at for the past ten years: _____
_____

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

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 ( ) - _____

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 ( ) - _____
Cell ( ) - _____
Fax ( ) - _____
Your E-mail: _____

2.e. Is the Injured Person: ❑ A Minor ❑ Deceased - If so, Date of Death: _____(PROVIDE COPY OF DEATH CERTIFICATE)

If Deceased, has an estate been opened: _____ Yes _____ No . If Yes, please include documents showing representative of estate.
If Deceased, please list he cause of death: _____
❑ Hospitalized ❑ Too sick to complete paperwork ❑ Other: _____

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 please fill it out from the Injured Person's perspective.

BOX 3: PRADAXA USE

Approximate date range you took Medication: From: _____ To: _____
If you have taken it on-and-off over time, note other times used here: _____

PLEASE INCLUDE ANY PHARMACY OR MEDICAL RECORDS YOU MIGHT HAVE NOTING USE

BOX 4: PHARMACY INFORMATION

4.a. Full Name of Pharmacy : _____

Address of Pharmacy:_____

Telephone Number of Pharmacy _____

4.b. Full Name of Pharmacy: _____

Address of Pharmacy: _____

Telephone Number of Pharmacy:_____

BOX 5: PRESCRIBING PHYSICIAN (LIST EACH)

5.a. Full Name of Physician : _____

Address of Physician:_____

Telephone Number of Physician: _____

5.b. Full Name of Physician: _____

Address of Physician: _____

Telephone Number of Physician:_____

BOX 6: PRE-EXISTING CONDITIONS - PRIOR TO USING PRADAXA HAD YOU ANY OF THE FOLLOWING:

Any prior bleeding episodes: ❑ Yes ❑ No - If Yes, describe:_____ date diagnosed: _____

Please list heart conditions: _____

Are you a smoker: ❑ Yes ❑ No - If Yes, number / day: _____

BOX 7: INJURIES

7.a. What did you experience **while you were using PRADAXA**? Check all that apply.

- ❑ Internal Bleeding — *Date(s):* _____
- ❑ Gastro-Intestinal (GI) Bleeding — *Date(s):* _____
- ❑ Brain Hemorrhage (Bleed) — *Date(s):* _____
- ❑ Kidney Bleeding — *Date(s):* _____
- ❑ Other Bleeding: Describe:_____ — *Date(s):* _____
- ❑ Death — *Date:* _____

7.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):

_____

_____

_____

_____

PLEASE PROVIDE ANY MEDICAL RECORDS (IF ANY) YOU PRESENTLY HAVE CONCERNING YOUR CONDITION AND TREATMENT

BOX 8: PHYSICIANS MONITORING YOUR CONDITION NOW

Names/Addresses of all doctors who are following you for the Medical Events you marked in the previous 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 9: ADDITIONAL INFORMATION

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

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

ELECTRONIC SIGNATURE

Please sign your signature in the box below using blue or black ink. Please do not sign on the line but rather in the center of the space. This will allow us to use your signature electronically for purposes of ordering medical records.

YOUR SIGNATURE WILL NOT BE USED FOR ANY OTHER PURPOSE.