XARELTO 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

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

[ ] Hospitalized [ ] Too sick to complete paperwork [ ] Other: _____

If Deceased, has an estate been opened: _____ Yes _____ No . If Yes, please include documents showing representative of estate.

If Deceased, please list the cause of death: _____

(PROVIDE COPY OF DEATH CERTIFICATE)

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: XARELTO USE

Approximate date range you took Medication: From: _____ To: _____

If you have taken it on-and-off over time, note other times used here: _____

For what condition(s) were you prescribed Xarelto: _____

Who was your medical insurance carrier (s) at the time(s) of your Xarelto 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 XARELTO, HAVE YOU HAD 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 XARELTO**? Check all that apply.

[ ] Internal Bleeding — *Date(s):* _____
[ ] Gastro-Intestinal (GI) — *Date(s):* _____
[ ] Brain Hemorrhage — *Date(s):* _____
[ ] Kidney — *Date(s):* _____
[ ] Other Bleeding: _____ — *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 and/or Hospital: _____
Address (including hospital or clinic name, if applicable):
_____

Medical Event: _____ Date: _____
Doctor and/or Hospital: _____
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 Xarelto 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: