BIRTH CONTROL 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):
____
____
____
____

1.c. 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: ________________________
____

1.d. 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.e. 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

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: ❑ A Minor ❑ Deceased ❑ Hospitalized ❑ Ill ❑ 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: MEDICATION / IMPLANT USAGE

Which did you use: _____ YAZ _______ YASMIN _______ OCELLA __________ BEYAZ __________ NUVARING

3. Approximate date range you used Medication / Implant: From: __________ To: __________
(If you have taken it on-and-off over time, note those below)
____

PLEASE SEND US A COPY OF YOUR PHARMACY / PRESCRIPTION PRINTOUT IF YOU HAVE

BOX 4: PHYSICIAN AND PHARMACY INFORMATION

4.a. Prescribing Physician's Information *If more than one physician prescribed your medication, please use extra paper.*

Prescribing Physician's Name: ______________________________

Telephone: (______) ________-____________

Address (including hospital or clinic name, if applicable):

____

____

____

____

4.b. Pharmacy Information *If more than one pharmacy filled your prescriptions, please use extra paper to list.*

Pharmacy Name: ______________________________

Telephone: (______) ________-____________

Address: ______________________________

____

____

____

____

BOX 5: MEDICAL EVENTS AND TREATMENT

5.a. Did you experience any of the following Medical Events while using any of the medications / implants? Check all that apply.

❑ **Stroke** Date Diagnosed: ______________ (If Yes - see box below about Stroke / Heart Attack)

❑ **Heart Attack** Date Diagnosed: ______________ (If Yes - see box below about Stroke / Heart Attack)

❑ **Blood Clots (Arm / Leg)** Date Diagnosed: ______________ (If Yes - see box below about Blood Clots)

❑ **Pulmonary Embolism (Blood Clot in Lung)** Date Diagnosed: _______________ (If Yes - see box below about Blood Clots)

❑ **Other Serious Cardiac Event** - Describe and complete box 5.d below: _______________________________

5.b. IF YOU HAD A STROKE OR A HEART ATTACK WHILE USING MEDICATION / PRODUCT, COMPLETE THE FOLLOWING:

DATE OF STROKE/HEART ATTACK: ________________

Doctor: ______________________________

Was this an emergency room doctor? ❑ Yes ❑ No

Doctor's Address (including hospital or clinic name, if applicable):

____

____

____

HAVE YOU FULLY RECOVERED FROM THE EVENT: ❑ Yes ❑ No

If No, Describe present restrictions: ______________________

____

Were you hospitalized for treatment: : ❑ Yes ❑ No

If Yes, Hospital Name / Address:

____

____

____

DO YOU UNDERGO THERAPY OR TREATMENT AS A RESULT OF THIS EVENT: ❑ Yes ❑ No

If Yes, describe: ______________________________

____

Did they place you on medication for this - if yes, list meds:

____

5.c. IF YOU WERE DIAGNOSED WITH BLOOD CLOTS WHILE USING MEDICATION / PRODUCT, COMPLETE THE FOLLOWING:

DATE DIAGNOSED WITH BLOOD CLOTS: ___________

Doctor: ______________________________

Was this an emergency room doctor? ❑ Yes ❑ No

Doctor's Address (including hospital or clinic name, if applicable):

____

____

____

Were you hospitalized to treat the blood clots: : ❑ Yes ❑ No

If Yes, Hospital Name / Address:

____

____

____

Have the blood clots resolved**:** ❑ Yes ❑ No

In what part of your body were the clots located (for example: Lung, leg, etc.): ______________________________

____

____

Are you having to take medication as a result: ❑ Yes ❑ No

If you are taking medication, what are you taking:

____

____

____

5.d. IF YOU WERE DIAGNOSED WITH OTHER SERIOUS CARDIAC EVENTS WHILE USING MEDICATION, COMPLETE THE FOLLOWING:

DATE DIAGNOSED: ________________________________
Doctor: ________________________________
Was this an emergency room doctor? ❑ Yes ❑ No
Doctor's Address (including hospital or clinic name, if applicable):
____
____
____

Were you hospitalized : ❑ Yes ❑ No
If Yes, Hospital Name / Address:
____
____
____
Are you taking medications for this**:** ❑ Yes ❑ No
If Yes - what: ________________________________

BOX 6: ADDITIONAL INFORMATION

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

If you were represented by another attorney - are you still represented by that firm: ❑ Yes ❑ No

If no longer represented by that firm, please explain why: ____

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

BOX 7: INSURANCE INFORMATION

7a. Did you have group or private insurance at the time of injury? ❑ Yes ❑ No

If yes, list the insurer and policy number: ____

7b. Did you have Medicaid at the time of injury? ❑ Yes ❑ No

If yes, list the contract number: ____

7c. Did you have Medicare at time of injury? ❑ Yes ❑ No

If yes, list the contract number: ____

7d. Did you have any other medical insurance at the time of injury? ❑ Yes ❑ No

If yes, list the insurer, policy and/or contract: ____

PLEASE ENCLOSE COPIES OF ANY MEDICAL AND/OR PHARMACY RECORDS RELATED TO YOUR USE OF MEDICATION AND THE EVENTS / PROBLEMS YOU EXPERIENCED IF YOU HAVE ANY.

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.