TAXOTERE
CLIENT QUESTIONNAIRE

INJURED PARTY'S BACKGROUND INFORMATION:

Note: If you are filling out this form for a deceased person, or person for whom you have Power of Attorney, put their information in this section.

Title: _____ First: _____ Middle: _____ Last: _____ Suffix: _____

Prior/Maiden/Other: _____ SSN: _____ DOB: _____ Sex: Male ☐ Female ☐

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ County: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Work Phone: (_____) _____ Email: _____

Occupation: _____ Highest Education: _____ Birthplace: _____

Do you speak English? Yes ☐ No ☐ Primary language? _____

Is the injured party deceased? Yes ☐ No ☐ Do you have death certificate? Yes ☐ No ☐

Date of Death: _____ Cause of death: _____

Did deceased party have a will? Yes ☐ No ☐ Have estate proceedings been filed in court? Yes ☐ No ☐

Please Provide Previous Addresses for the last Five (5) years: (Include City, State, and Zip Code)

1. _____

2. _____

3. _____

REPRESENTATIVE INFORMATION (If client is deceased or you have power of attorney**):**

Title: _____ First: _____ Middle: _____ Last: _____ Suffix: _____

Prior / Maiden: _____ Other: _____ Relationship: _____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ County: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Work Phone: (_____) _____ Email: _____

Do you speak English? Yes ☐ No ☐ Primary language? _____

INJURED PARTY'S FAMILY INFORMATION:

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Deceased ☐

Spouse Name: _____

Spouse SSN: _____ Spouse DOB: _____

Spouse Work: (_____) _____ Spouse Cell: (_____) _____

Full Name(s) of Children: _____

_____

INJURED PARTY'S LIEN/BANKRUPTCY INFORMATION:

1. Have you ever had Medicare? Yes ☐ No ☐

2. Have you ever had Medicaid? Yes ☐ No ☐

3. Have you filed bankruptcy in the last five years? Yes ☐ No ☐

If yes, please provide, if known, the following:

Bankruptcy Court: _____ Case No.: _____

Bankruptcy Trustee Name: _____

INJURED PARTY'S GENERAL BACKGROUND/MEDICAL INFORMATION:

1. Current Height:_____ Current Weight:_____

2. Were you diagnosed with breast cancer? Yes ☐ No ☐ If yes, what was your diagnosis date? Date: _____

Name of diagnosing or treating Physician 1:_____

Address: _____ City:_____

State: _____ Zip: _____ Telephone:_____

Name of diagnosing or treating Physician 2:_____

Address: _____ City:_____

State: _____ Zip: _____ Telephone:_____

3. Were you diagnosed with any other type(s) of cancer? Yes ☐ No ☐

If yes, what was the date of your diagnosis? Date: _____ Treating Physician Name and Address:_____

_____

TAXOTERE USAGE:

1. Was the injured party prescribed or administered Taxotere? Yes ☐ No ☐

2. During what period of time was Taxotere used for chemotherapy treatment?

Start Date:_____ **Stop Date:**_____

3. List all doctors who prescribed, and all facilities where you received, Taxotere or other chemotherapy treatments:

Medical Provider 1

Hospital/Doctor/Facility:_____

Address: _____

City: _____ State: _____ Zip: _____ Telephone:_____

Start Date: _____/_____/_____ End Date: _____/_____/_____ Dosage (if known): _____

Did the injured party receive any information / counseling on the effects of the drug? Yes ☐ No ☐

If yes, please describe: _____

Medical Provider 2

Hospital/Doctor/Facility: _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Start Date: _____/_____/_____ End Date: _____/_____/_____ Dosage: Dosage (if known): _____

Did the injured party receive any information / counseling on the effects of the drug? Yes ☐ No ☐

If yes, please describe: _____

Medical Provider 3

Hospital/Doctor/Facility: _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Start Date: _____/_____/_____ End Date: _____/_____/_____ Dosage: Dosage (if known): _____

Did the injured party receive any information / counseling on the effects of the drug? Yes ☐ No ☐

If yes, please describe: _____

INJURY RELATED INFORMATION:

What injury or injuries did the injured party suffer **AFTER** administration of Taxotere?

1. **Permanent hair loss (permanent alopecia):** Yes ☐ No ☐ *If yes, please complete the following:*

Details regarding the extent and duration of your hair loss: _____

_____

_____

_____

a. If you answered Yes to the above, have you discussed your hair loss with a doctor? If yes, provide names:

Name of Physician 1: _____ Date of first visit, if known: ____/_____/_____

Address: _____ City: _____

State: _____ Zip: _____ Telephone: _____

Name of Physician 2: _____ Date of first visit, if known: ____/_____/_____

Address: _____ City: _____

State: _____ Zip: _____

Telephone: _____

2. **Other injury or injuries?** Yes ☐ No ☐ *If yes, please complete the following:*

Description of Damage: _____

Date: _____

Treating Physician / Hospital: _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

3. Have you ever experienced any of the injuries above prior to being administered Taxotere? Yes ☐ No ☐

If yes, which injury(ies): _____

Date(s): _____

ADDITIONAL INFORMATON:

1. When did you first come to believe that your hair loss or other injury could be related to your use of Taxotere?

Date:_____ Details:_____

_____

_____

_____

DOCUMENTS:

If you are in possession of any of the following documents please enclose:

1. Copies of medical records showing administration of Taxotere;
2. Copies of any medical or billing records from pharmacies and/or physicians relating to your cancer treatments or your alleged injuries;
3. Copies of any documents (i.e. instructions, warnings, advertisements) relating to Taxotere obtained from your physician, medical providers, or a newspaper or other advertisement;
4. Current photographs of the injured party showing hair loss; and
5. If the injured party is deceased, copies of any death certificate, last will, and or probate documents.

If you cannot get some or all of these documents, please return the enclosed paperwork and we will request the documents for you and/or obtain them at a later time.