PAXIL QUESTIONNAIRE

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CONTACT: (The person who contacts us requesting information)

Last Name: ____________________ First Name: ____________________ MI: ________

Home Phone: ____________________ Work Phone: ______________ Email: ________________

Street Address: ________________________________ City: __________________________

County: ______________________ State: __________________ Zip: ________________

CLIENT: (The potential plaintiff)

Last Name: ____________________ First Name: ____________________ MI: ________

Home Phone: ____________________ Work Phone: ______________ Email: ________________

Street Address: ________________________________ City: __________________________

County: ______________________ State: __________________ Zip: ________________

Social Security #: _________________ Date of Birth: ______________ Date of Death: ___________

Was an autopsy performed? __________ In what County and State was the autopsy performed? _______

EMERGENCY CONTACT INFORMATION:

(LITIGATION AGAINST PHARMACEUTICAL COMPANIES FREQUENTLY LASTS SEVERAL YEARS. OUR EXPERIENCE IS THAT PEOPLE MOVE DURING THAT TIME AND OFTEN FORGET TO NOTIFY US OF THEIR NEW CONTACT INFORMATION. PLEASE REMEMBER TO NOTIFY US IF YOU MOVE AND CHANGE YOUR CONTACT INFORMATION. PLEASE ALSO PROVIDE US WITH CONTACT INFORMATION OF SOMEONE WHO WILL ALWAYS KNOW HOW TO REACH YOU.)

Last Name: __________________ First Name: ____________________ MI: ____ Male/Female ___

Home Phone: ____________________ Work Phone: ______________ Email: ________________

Street Address: ________________________________ City: __________________________

County: ______________________ State: __________________ Zip: ________________

PAXIL EXPOSURE:

Who prescribed PAXIL for you?

Prescribing doctor's name: ______________Address: ______________________ City: ________________

Dosage given: ______________________________________ Dosage Taken: ______________________

Date taken: ___/___/___ Date Stopped ___/_____/_____ Total time taken: ______________________

Prescribing doctor's name: ______________Address: ______________________ City: ________________

Dosage given: ______________________________________ Dosage Taken: ______________________

Date taken: ___/___/___ Date Stopped ___/_____/_____ Total time taken: ______________________

Pharmacy Name: ____________________________________ Street Address: _____________________

City: ____________________________ State: _________ Zip: _________ Phone: _______________

Pharmacy Name: ____________________________________ Street Address: _____________________

City: ____________________________ State: _________ Zip: _________ Phone: _______________

Why was PAXIL prescribed for you?____

What did the doctor who prescribed PAXIL for you tell he was prescribing PAXIL for? _______________

Were you pregnant when the doctor prescribed PAXIL for you? __________________________________

Did you become pregnant while you were taking PAXIL?____

When the doctor prescribed PAXIL for you, did you tell the doctor that:

□ **you were pregnant?** □ **you were thinking about getting pregnant?**

When you learned you were pregnant, did you tell the doctor who that you were pregnant?

______________________________________If yes, how soon after you learned you were pregnant did you tell the doctor? ____

Did the doctor who prescribed PAXIL for you tell you that you cannot take PAXIL if you are pregnant?

____

Did the doctor who prescribed PAXIL for you tell you that PAXIL can cause heart defects in unborn babies?

____

Did the doctor who prescribed PAXIL for you tell you that PAXIL can cause a deadly lung disease called PERSISTENT PULMONARY HYPERTENSION (PPHN) in newborn babies?

____

Did the doctor who prescribed PAXIL for you discuss the risks and benefits of your take PAXIL while you were pregnant? ____

Did the doctor who prescribed PAXIL for you discuss the other drugs you could take instead of PAXIL while you were pregnant? ____

After taking PAXIL during your pregnancy, was your child born with cardiac defects? ___________

After taking PAXIL during your pregnancy, was your child born with an atrial or ventricular septal defect (Conditions in which the wall between the right and left sides of the heart is not completely developed.)? ______________________________

After taking PAXIL during your pregnancy, was your child born with and/or diagnosed with PERSISTENT PULMONARY HYPERTENSION (PPHN)? ______________________________

Diagnosing doctor's name: ______________ Address: ______________________ City: ________________

Diagnosis date: ____/____/____

Treatment given to your child for cardiac defects? ______________________________

____

____

Treatment given to your child for **PERSISTENT PULMONARY HYPERTENSION (PPHN)?**

____

Doctor's name: ______________ Address: ______________________ City: ________________

Pharmacy Name: ______________________________ Street Address: ______________________

City: ______________________ State: __________ Zip: __________ Phone: ________________

Hospital Name: ______________________________ Street Address: ______________________

City: ______________________ State: __________ Zip: __________ Phone: ________________

YOUR MEDICAL HISTORY *PRIOR TO TAKING PAXIL*:

PRIOR TO TAKING PAXIL …

Were you born with a **heart defect**? ______________________________

Hospital Name: ______________________ Address: ______________________ City: ________________

Doctor's Name: ______________________ Address: ______________________ City: ________________

Had you been diagnosed by a doctor or at a hospital for PERSISTENT PULMONARY HYPERTENSION (PPHN)? ______________________________

Hospital Name: ______________________ Address: ______________________ City: ________________

Doctor's Name: ______________________ Address: ______________________ City: ________________

FAMILY MEDICAL HISTORY:

Do you have a family history of heart defects? ______ ______________________________

Who (parent, sibling, child, etc.)? ______________________________

Do you have a family history of **PERSISTENT PULMONARY HYPERTENSION (PPHN)?** ______________

Who (parent, sibling, child, etc.)? ______________________________

Do you have a family history of *Pulmonary Hypertension or Primary Pulmonary Hypertension?* __________

Who (parent, sibling, child, etc.)? ______________________________

How is your life different today as a result of your child's PAXIL related problems and illnesses?

____

____

Comments and/or Questions: ______________________________

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Initial Contact Date: ______________ Initial Contact Method: ______________

Date: ______________

Interviewer: ______________

Marketing Source possible answers should be one of the following:

Newspaper Advertising
TV Advertising
Atty Referral ______________
Newsletter
Union ______________
Telephone Directory
Website
Direct Mail
Previous Client
Word of Mouth