UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF LOUISIANA

In Re: Actos (Pioglitazone) Products Liability Litigation	*	6:11-md-2299
This Document Applies to:	*	XXXXX
_____	*	MAGISTRATE JUDGE XXXX

ACTOS® PLAINTIFF FACT SHEET

Each plaintiff who alleges personal injury as a result of taking ACTOS®, ACTOplus Met®, ACTOplus Met XR®, Duetact®, and/or any other medication containing pioglitazone hydrochloride approved for sale and marketing in the United States (collectively referred to as "Actos®") must complete a Fact Sheet. If you are completing this Fact Sheet in a representative capacity on behalf of someone who has died or who otherwise cannot complete the Fact Sheet, please answer as completely as you can for that person.

In completing this Fact Sheet, please use the following definitions: (1) "you" refers to the person who used Actos®, unless otherwise specified; (2) "healthcare provider" means any hospital, clinic, medical center, physician's office, urgent care center, infirmary, laboratory, or other facility that provides medical care or advice, and any pharmacy, physical therapist, rehabilitation specialist, physician, osteopath, homeopath, chiropractor, nurse, herbalist, nutritionist, dietician, or any other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you; and (3) "document" means any writing or record of any type in your possession or the possession of your attorney, including, but not limited to, written documents, e-mails, cassettes, videotapes, DVDs, photographs, medical records, charts, computer discs, tapes, or CDs, x-rays, drawings, graphs, non-identical copies, and other data from which information can be obtained and translated, if necessary, through electronic devices into a reasonably usable form. **You may attach as many sheets of paper as necessary to fully answer these questions.**

If you have any documents (as defined above), including, but not limited to, packaging, labeling, or instructions for Actos®, materials or items that you are requested to produce as part of answering this Fact Sheet or that relate to Actos®, or that relate to the injuries, claims, and/or damages that are the subject of your complaint, you must NOT dispose of, alter, or modify these documents or materials in any way. You are required to give all of these documents and materials to your attorney as soon as possible. If you are unclear about these obligations, please contact your attorney.

In completing the Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You must supplement your responses if you learn that they are incomplete or incorrect.

I. Case Information

A. Your Attorney's Name:_____

Firm:_____

Address:_____

Telephone Number:_____

Fax Number:_____

E-Mail Address:_____

B. If you are completing this Fact Sheet in a representative capacity (on behalf of the estate of a deceased person or a minor), please complete the following:

1. Your name:_____

2. Your address:_____

_____

3. The individual/estate you are representing:_____

4. Your relationship to that individual/estate:_____

5. If you were appointed as a representative by a court, please state the:

Court that appointed you:_____

Date of appointment:_____

The names of any other representatives appointed by the Court:_____

_____

6. If you represent a decedent's estate, please state the:

Date of the decedent's death:_____

Place of the decedent's death:_____

THE REMAINDER OF THIS FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO USED ACTOS®. IF YOU ARE COMPLETING THIS FACT SHEET FOR SOMEONE ELSE, PLEASE ASSUME THAT "YOU" MEANS THE ACTOS® USER.

II. Personal Information for the Actos® User

A. Name: XXXXX *(Per client questionnaire)*

B. Have you ever used any other names and, if so, when: _____

C. Address: NNNN XXXX, XXXX, XX-NNNN *(Per client questionnaire)*

How long have you lived at this address? _____

D. Social Security Number: XXX-XX-XXX *(Per client questionnaire)*

E. Date and place of birth: MM/DD/YYYY, YYYY, YY. *(Per client questionnaire)*

F. Sex: Male: X *(Per client questionnaire)* Female: _____

G. Ethnicity: XXXXX Caucasian X Hispanic _____ Native American _____

Other (please specify) _____

H. Marital Status: Widowed *(Per client questionnaire)*

I. Spouse's name and date of marriage: _____

Has your spouse filed a loss of consortium or other claim in connection with this lawsuit?
Yes _____ No _____ N/A _____

J. If you have children, please state each child's name and date of birth: _____
Daughter -XXXX, MM/DD/YYYY *(Per client questionnaire)*

K. Have you ever served in any branch of the military? Yes _____ No X

1. If yes, branch and dates of service: _____
2. Were you ever rejected or discharged from military service for any reason related to your medical, physical, or psychiatric condition? Yes ____ No _____
3. If yes, state the reason and date: _____

L. Education:

1. Provide the following information regarding your education, beginning with high school and continuing through your highest level of education:

Name of School	**City/State**	**Degree awarded and/or area of study/major**	**Dates of Attendance**
Unknown		Bachelor	

M. Are you currently employed? Yes _____ No __X XXXX-Retired_ *(Per client questionnaire)*_____

If yes, please identify your current employer with name, address, and telephone number, and your occupation:_____

_____

_____

_____

If not, did you leave your last job for a medical reason? Yes _____ No _____

If yes, describe why you left:_____

_____

Are you making a claim for lost wages or lost earning capacity? Yes ____ No _____

N. Please complete the following information regarding any employers (other than your current employer) that you have had in the last ten (10) years, or at any time since your first ingestion of Actos®, whichever is longer:

Name of Employer	**Address & Phone No.**	**Job Title/Duties**	**Dates Employed**

O. During the previous ten (10) years, or at any time since your first ingestion of Actos®, whichever is longer, have you been out of work for more than thirty (30) days during any calendar year for reasons related to your health (medical, physical, psychiatric or emotional condition)?

Yes _____ No _____

If yes, please state the dates, employer, and health condition:_____

_____

P. Identify each insurance carrier with whom you have had health insurance coverage at any time during the past ten (10) years:

Insurance Company	Policy Number	Policy Holder	Dates of Coverage
Health First M'Care HMO	XXXXX	Unknown	Unknown
Health First	XXXXX	Unknown	Unknown

Q. Have you ever received Medicare, Medicaid or other government medical benefits within the past ten (10) years? Yes _____ No _____

If yes, please describe the benefits received: _____

_____

R. Have you applied for workers' compensation, social security, and/or state or federal disability benefits within the past ten (10) years? Yes ___X__ No _____

If yes, then as to each application, separately state: *(Per client questionnaire)*

1. Date (or year) of application: _____MM/YYYY_____
2. Nature of the claimed injury/disability: __Neuropathy_____
3. The agencies to which you submitted your application:_____

_____

S. At any point during the previous ten (10) years, have you ever been convicted of, or pled guilty to, a felony? Yes _____ No _____

If yes, please describe the charge to which you pled guilty or were convicted of, the court, and the outcome:_____

_____

_____

T. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury? Yes _____ No _____

If yes, please state the following:

1. Party you sued or made a claim against: _____
2. Court in which suit was filed: _____
3. Case/claim number: _____
4. Attorney who represented you: _____
5. Nature of injury/claim: _____

III. Use of Actos®

Date(s) of Use	Medication Prescribed	Dose	Name and Address of Prescribing Physician	Name and Address of Dispensing Pharmacy or where Actos was obtained
Year: 2001-2005 *Per client questionnaire*	Actos	45 mg	Dr. XXXXX XXXXX, M.D. XXXX Street, XXXX, XX	Walgreens Pharmacy XXXX CVS Pharmacy XXXX *(Per client questionnaire)*
From MM/DD/YYYY-MM/DD/YYYY *Per medical records*	Actos	45 mg	XXXXX, M.D.	Unknown

.

A. Do you currently use Actos®? Yes _____ No __X (Stop Actos)_____

B. Has any healthcare provider recommended that you not use Actos® or that you discontinue your use of Actos®? Yes __X___ No _____

If yes, state the name and address of the healthcare provider and the date the recommendation was made: XXXXX, M.D.

*If any such advice or recommendation was given in writing, please attach a copy.

C. Did you ever receive any samples of Actos®? Yes_____ No_____

If you answered yes, please state the following:

1. Who provided the samples? _____

2. When were the samples provided? _____

3. Did you request to any healthcare provider that he or she prescribe you Actos®?

   Yes_____ No _____

   If yes, which healthcare provider(s)? _____

D. Have you had any direct communication, written or oral, with Takeda Pharmaceutical Company, Takeda Pharmaceuticals U.S.A., Inc. (formerly known as Takeda Pharmaceuticals North America, Inc.), Takeda Pharmaceuticals America, Inc., and/or Eli Lilly and Company or any of their representatives?

   Yes _____ No _____

   If yes, please describe the communication and the approximate date(s) on which it occurred:

   _____

   _____

E. Did you ever receive any written and/or oral information about Actos®? Yes___ No ___

   If yes, please specify the information you received:_____

   _____

   If yes, who provided this information?_____

   _____

F. Have you ever received assistance through a Patient Assistance Program for Actos®?

   Yes _____ No _____

   If yes, please identify the approximate dates during which you received assistance through the program:

   _____

G. Have you ever visited a website, chatroom, message board, or other electronic forum containing information or discussion about Actos®? Yes_____ No_____ Unsure_____

   If yes, please provide the name of the website(s):_____

   _____

   If yes, please identify the approximate date(s) on which you visited the website(s):_____

   _____

IV. Healthcare Providers and Pharmacies

A. Identify the following for each healthcare provider with whom you have consulted during the previous ten (10) years, or five (5) years prior to your first ingestion of Actos®, whichever is longer, to the present (or, if you are a minor, please list all healthcare providers):

Name & Specialty	**Address & Phone Number**	**Dates of Treatment (Provide approx date(s) if precise date(s) are unknown)**	**Reason for Treatment**

B. Identify the following for each time you were hospitalized and/or received treatment in an emergency room or an out-patient setting during the previous ten (10) years, or five (5) years prior to your first ingestion of Actos® , whichever is longer, to the present (or, if you are a minor, please list all hospitalizations):

Name of Facility	**Address & Phone Number**	**Dates of Treatment (Provide approx date(s) if precise date(s) are unknown)**	**Reason for Treatment**

C. Identify the following for each pharmacy, drug store and/or other supplier (including mail order and internet pharmacies) where you have filled prescriptions during the previous ten (10) years, or five (5) years prior to your first ingestion of Actos®, whichever is longer, to the present (or, if you are a minor, please list all pharmacies or other medication suppliers):

Name	Address & Phone Number

V. Injuries and Damages Alleged

A. Are you claiming that you suffered bodily injury as a result of taking Actos®?

Yes __X___ No _____ *(Per client questionnaire)*

If you answered yes, please identify and describe your alleged injury(ies) and dates of diagnosis:

_____2006, _*Not available*_____
_____
_____
_____
_____
_____
_____

B. To the extent not set forth in Section IV.A and IV.B above, please identify the following information for the healthcare providers who rendered care and treatment to you for the injury(ies) you allege above:

Name & address of Healthcare Provider(s) who rendered care and treatment to you for alleged Injury(ies)	Reason for Treatment
Dr. XXXXX 1223 XXXX Dr., XXXX	First diagnosed MM/DD/YYYY after first cystoscopy BCG treatments

	First treatments-MM/YYYY Last treatment-MM/YYYY *(Per client questionnaire)*
YYYY Medical Center XXXX, FL	MM/DD/YYYY: Cystoscopy, Bilateral retrograde pyelography, Bladder biopsies, Urethral dilatation, Transurethral fulguration of the bladder.
YYYYY Surgery, XXXXX, Florida	MM/DD/YYYY: Cystoscopy, bilateral retrograde pyelography. MM/DD/YYYY: Cystoscopy, bilateral retrograde pyelography. MM/DD/YYYY: Cystoscopy, bilateral retrograde pyelography.

C. Has any healthcare provider told you that any of your alleged injury(ies) is the result of your use of Actos®? Yes_____ No_____

If yes, provide the healthcare provider's name and address and the approximate date of this conversation:_____

_____

_____

D. Did you ever experience the type of injury or injury(ies) you allege were caused by Actos® prior to the date(s) set forth above? Yes _____ No __X____ *(Per client questionnaire)*

If yes, please identify which injury(ies) and when you experienced them: _____

_____

_____

_____

If yes, please identify any healthcare provider(s) with whom you have treated for this alleged injury, including their name and address:_____

_____

_____

E. Are you claiming that you have paid, or will have to pay, any monetary expenses or fees for medical treatment as a result of having taken Actos®? Yes_____ No_____

If yes, please describe:_____

F. Are you claiming in this case that you suffered psychiatric or psychological injury as a result of your use of Actos®? Yes_____ No_____ 14

If yes, please describe:_____

If yes, please identify any healthcare provider(s) with whom you have treated for this alleged injury, including their name and address:_____

VI. Medical Background of the Actos® User

A. Current Height __5'7"_ Current Weight _230 lbs *(Per client questionnaire)*_

B. Smoking History:

C. Have you ever smoked cigarettes? Yes_____ No _X *(Per client questionnaire)*_

If yes, when did you smoke? _____

If yes, how many cigarettes/packs per day/week?_____

Have your smoking habits changed over time? _____

1. Do you currently smoke cigarettes? Yes_____ No ___X__

If yes, how much do you currently smoke? _____

D. Alcohol History:

1. Do you currently drink alcohol (beer, wine, liquor, etc.)? Yes_____ No ____X_

If yes, how many drinks per week/month/year? _____

2. During the previous ten (10) years, have you consumed alcohol? Yes__ No _X__

If yes, during what period of time did you consume alcohol?

_____

How many drinks per week/month/year did you consume?

_____

E. Use of Illicit Drugs:

1. During the previous ten (10) years, have you used any illicit drugs of any kind (such as cocaine, crack, heroin, or LSD) without a prescription? Yes_____ No ___X_

If yes, which drug(s)? _____

If yes, when? _____

F. Medical History: Have you ever been diagnosed with any of the following?

Condition	**Yes**	**No**	**Unknown**	**Date of Diagnosis** (Provide approx date(s) if precise date(s) are unknown)
Type II diabetes mellitus	Yes			Year: 1989
Type I diabetes mellitus			Unknown	
Gestational diabetes			Unknown	
Diabetic coma			Unknown	
Diabetic ketoacidosis (DKA)			Unknown	
Diabetic ketosis			Unknown	
Hyperglycemia (high blood sugar)	Yes			
Glycosuria/glucosuria (sugar in your urine)			Unknown	
Impaired fasting glucose, pre-diabetes			Unknown	
Insulin resistance			Unknown	
Metabolic syndrome			Unknown	
Other problems related to blood sugar, glucose, ketones, or insulin			Unknown	
High cholesterol	Yes			
High blood pressure	Yes			
Bladder cancer	Yes			MM/DD/YYYY
Other cancer (please specify below)			Unknown	
Type(s) of cancer				
Bladder infection			Unknown	
Urinary tract infection or blockage	Yes			MM/DD/YYYY
Enlarged prostate	Yes			
Hyperplasia				
Kidney disease	Yes			
Kidney stones		No		
Myocardial infarction	Yes			
Cerebrovascular disease, including stroke		No		
Coronary artery disease	Yes			
Congestive heart failure	Yes			

G. *Other than* those injuries that you believe were caused by your use of Actos®, do you currently suffer from any physical injuries or disabilities? Yes_____ No_____

If yes, please identify:

The injury, illness, or disability: _____

Date(s) of onset: _____

Date(s) of diagnosis: _____

Name and address of treating physician:_____

_____

VII. Medications

Do you currently take, or have you ever taken, any of the following medications:

Medication	**Yes**	**No**	**Unknown**	**If yes, dose and dates of usage** (Provide approx date(s) if precise date(s) are unknown)
Metformin	Yes			MM/DD/YYYY MM/DD/YYYY: 1000 mg MM/DD/YYYY: 1000 mg MM/DD/YYYY
Avandia	Yes			MM/DD/YYYY- MM/DD/YYYY: 8 mg MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY: 4 mg MM/DD/YYYY: 4 mg MM/DD/YYYY MM/DD/YYYY: 4 mg MM/DD/YYYY
Rezulin	Yes			MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY: 400 mg MM/DD/YYYY
Glucophage	Yes			MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY: 500 mg
Fortamet			Unknown	
Glyset			Unknown	
Precose			Unknown	
Prandin (Repaglinide)			Unknown	
Starlix (Nateglinide)	Yes			MM/DD/YYYY- MM/DD/YYYY MM/DD/YYYY- MM/DD/YYYY: 120 mg
Lispro (Humalog)			Unknown	
DiaBeta (Glyburide)	Yes			MM/DD/YYYY- MM/DD/YYYY: 5 mg MM/DD/YYYY- MM/DD/YYYY: 5 mg
Glargine/Lantus	Yes			MM/DD/YYYY

				MM/DD/YYYY MM/DD/YYYY
Glulinine			Unknown	
Levemir (Detemir)			Unknown	
Glucotrol (Glipizide)	Yes			MM/DD/YYYY
Amaryl (Glimepiride)	Yes			MM/DD/YYYY-MM/DD/YYYY
Dymelor			Unknown	
Glynase/PresTab			Unknown	
Micronase			Unknown	
Orinase			Unknown	
Tolinase			Unknown	
Symlin (Pramlintide)			Unknown	
Januvia (Sitagliptin)	Yes			MM/DD/YYYY- MM/DD/YYYY: 100 mg MM/DD/YYYY- MM/DD/YYYY
Byetta (Exenatide)	Yes			MM/DD/YYYY- MM/DD/YYYY
Other medications used to treat diabetes (specify _____)			Unknown	
Cyclophasmamide (Cytoxan)			Unknown	
Empirin compound			Unknown	
Ifosfamide (Ifex)			Unknown	
Phenacetin			Unknown	
Aristolochiafangchi			Unknown	

VIII. Family Medical History

To the best of your knowledge, please indicate whether your *parents, siblings, children or grandparents* have ever suffered from or been treated for any of the following:

Condition	**Yes**	**No**	**Unknown**	**If yes, identify the family relationship(s)**
Diabetes mellitus	Yes			Mother
Hyperglycemia				
Glucose intolerance				
Cancer (If yes, please specify _____)				
Kidney disease				
Kidney stones				
Hyperplasia				
Enlarged prostate				

IX. Fact Witnesses

A. Other than your healthcare providers, please identify all persons whom you believe possess information concerning your alleged injury and/or other facts related to your claim:

Name	**Address**	**Relationship to you**

X. Declaration

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information and belief formed after due diligence and reasonable inquiry.

Date: _____ Signature: _____

XI. Documents: These Document Demands are made pursuant to Fed.R.Civ.P. 34.

A. Please sign and attach to this Fact Sheet authorizations allowing for release of all relevant records. (Please be sure that either you or your attorney complete the top portion of each authorization form for each provider for whom an authorization is being provided).

B. If completing this Fact Sheet on behalf of a deceased person, please attach the legal documentation establishing that you are the legal representative of the estate and the Decedent's death certificate and autopsy report (if applicable).

C. Please indicate whether you or your counsel have any of the following materials in your possession by placing a checkmark next to the word "yes" or "no." **If yes, attach a copy of any such documents. In responding, note that Actos® is pioglitazone hydrochloride.**

1. Medical records from any physician, hospital or healthcare provider for the previous ten (10) years or five (5) years prior to your first ingestion of Actos®, whichever is longer, to the present. Yes____ No ____

2. Pharmacy records for the previous ten (10) years or five (5) years prior to your first ingestion of Actos®, whichever is longer, to the present, including receipts, prescriptions or records of purchase. Yes____ No____

3. Advertisements for Actos® or articles discussing Actos® which you reviewed before and during the time you took Actos®. Yes____ No____

4. The packaging, including the box and label, for Actos® and any remaining medication (plaintiffs must retain the originals of the items requested). Yes____ No____

5. Product use instructions, product warnings, package inserts, pharmacy handouts or other materials distributed with or provided to you in connection with your use of Actos®. Yes____ No____

6. Any other documents or materials that mention Actos®, or any alleged health risks or hazards related to Actos® in your possession at or before the time of the injury alleged in your complaint.
Yes____ No____

7. Statements obtained from or given by any person, other than your attorney(s) or retained expert(s), having knowledge of facts relevant to the subject of this litigation.
Yes____ No____

8. Documents that were provided to you by any of the defendants. Yes____ No____

9. Documents constituting any communications or correspondence between you and any representative of the defendants. Yes____ No____

10. Photographs, drawings, journals, slides, videos, DVDs or any other media relating to your alleged injury or the quality of your life after developing the injury that you allege is the result of Actos®. Yes____ No____

11. If you claim you have suffered a loss of earnings or earnings capacity, your W-2s and/or any other tax records reflecting your income for each of the last five (5) years. Yes____ No____

12. If you claim you have suffered a loss of earnings or earnings capacity, all employment records in your possession, including employment applications, performance evaluations, paychecks and pay stubs for the five (5) years prior to the injury that you associate with Actos®, whichever is longer, to the present.
Yes____ No____

13. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other healthcare provider documenting those medical expenses. Yes____ No____

14. If you have been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding that are in your possession. Yes____ No____

15. Journals, diaries, notes, letters, e-mails, tweets, Facebook posts, internet postings, and any other documents written or received by you (excluding communications to or from your attorney) within the previous ten (10) years which relate to Actos or the injuries you allege in this case. Yes____ No____

16. Print-outs of all websites or blogs which are maintained or created by you. Yes____ No____

XII. Certification of Counsel

Undersigned counsel for plaintiff(s) (Counsel) certifies that Counsel and/or members or associates in Counsel's firm instructed Plaintiff(s), Plaintiffs' other current or former attorneys and/or agents for any of the foregoing, to engage in best efforts to identify, locate and supply all responsive documents demanded in the Request to Produce to Plaintiff(s) approved by Case Management Order: Plaintiff Fact Sheets (July 9, 2012) that were in the custody or control of Counsel, Plaintiff, Plaintiffs' other current or former attorneys and/or agents for any of the foregoing, and Counsel further certifies that Counsel has a good faith belief that these instructions were followed by all of the aforementioned persons.

Date: _____ Signature: _____