SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF ALAMEDA

COORDINATED PROCEEDINGS SPECIAL TITLE (RULE 3.550(b))	)	**JCCP No. 4887**
ESSURE PRODUCT CASES	)	

PLAINTIFF FACT SHEET

In completing this Plaintiff Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. The Plaintiff Fact Sheet shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order. If you are completing this Plaintiff Fact Sheet in a representative capacity, please assume that "You" means the person who received Essure.

In filling out this form, please use the following definitions: (1) "**health care provider**" means any hospital, clinic, medical center, physician's office, dental office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dental, dietary, psychiatric or psychological care or advice, and any pharmacy, weight loss center, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care, and/or treatment of you; (2) "**document**" means any writing or recording of every type that is in your possession, including, but not limited to, written documents, documents in electronic format, cassettes, videotapes, photographs, charts, computer discs or tapes, media, x-rays, drawings, graphs, phone-records, non-identical copies, and other data from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form.

Please provide an answer for each question, and do not leave any answer space blank. Please answer each question as completely as possible. If you do not know or cannot recall information needed to answer a question, please indicate that in the response. If a question is not applicable to you, indicate that it does not apply. If you are producing medical records, pharmacy records, documents or other materials in response to this Plaintiff Fact Sheet, you may reference specific medical records, pharmacy records, documents or materials in your response, but you still must provide a complete response to each question.

I. CASE INFORMATION

1. Provide the following information for the case you filed:

Caption:	
Court and Docket No.:	; Court Docket No.
Plaintiff's Attorney:	First Last

2. Please provide the following information for the individual on whose behalf this action was filed:

Name:	XXXX XXXX First Last
Address:	XXXX XXX UNK YYYY
Last 4 digits of Social Security Number:	XXXX
Date of Birth:	?? ?? ??

3. If you are completing this form in a representative capacity (*e.g.*, on behalf of the estate of a deceased person), please complete the following:

☑ N/A

Name:	First Last
Address:	
Relationship to Represented Person:	
Capacity in which you are representing the individual:	
If you were appointed as a representative by a court, provide the State, Court, and Case Number:	☐ N/A State: Court: Case No.:
State the date and place of death of decedent (if applicable):	☐ N/A Date: Place:

II. PERSONAL INFORMATION FOR THE ESSURE PATIENT

1. Full Name: XXXX (First) XXXX (Middle Name/Initial) XXXX (Last)

2. Maiden or other names used and dates you used those names: ☑ N/A

Name	Dates Used
XXXX	?? ?? ?? to ?? ?? ?? ☐ Present
	to ☐ Present
	to ☐ Present
	to ☐ Present
	to ☐ Present
	to ☐ Present

3. Current Address: XXXXX

XXXX UNK XXXX

4. Are you currently married? ☐ Yes ☑ No ☐ N/A

Name of spouse: _____ (First) (Middle Name/Initial) (Last)

5. Has your spouse filed a loss of consortium or other claim in this lawsuit? ☐ Yes ☑ No ☐ N/A

6. If you have children, please provide each child's name and date of birth:

☐ N/A

Child's Name	Date of Birth
?? (First) ?? (Last)	?? ?? ??
?? (First) ?? (Last)	?? ?? ??
First Last	
First Last	
First Last	
First Last	
First Last	
First Last	
First Last	
First Last	
First Last	
First Last	

7. Are you currently employed? ☐ Yes ☐ No

??

If yes, please identify your current employer and position:

Employer: _____ Position: _____

Employer: _____ Position: _____

Employer: _____ Position: _____

Beginning five (5) years preceding your Essure placement through the present, have you ever taken leave from this job or any other job for medical reasons?

☐ Yes ☐ No

??

If yes, describe when you took leave and the reason:

Date Leave Began: _____

Date Leave Ended: _____

Reason: _____

Date Leave Began: _____

Date Leave Ended: _____

Reason: _____

Date Leave Began: _____

Date Leave Ended: _____

Reason: _____

Date Leave Began: _____

Date Leave Ended: _____

Reason: _____

Date Leave Began: _____

Date Leave Ended: _____

Reason: _____

Date Leave Began: _____

Date Leave Ended: _____

Reason: _____

Date Leave Began: _____

Date Leave Ended: _____

Reason: _____

Date Leave Began: _____

Date Leave Ended: _____

Reason: _____

Date Leave Began: _____

Date Leave Ended: _____

Reason: _____

Date Leave Began: _____

Date Leave Ended: _____

Reason: _____

Date Leave Began: _____

Date Leave Ended: _____

Reason: _____

Date Leave Began: _____

Date Leave Ended: _____

Reason: _____

8. Have you applied for workers' compensation, social security, or state or federal disability benefits during the five (5) years preceding your Essure placement through the present?

☐ Yes ☐ No

??

If yes, then as to each application, separately state:

a. Type of application: _____
b. Date (or year) of application: _____
c. Nature of claimed injury/disability: _____
d. Outcome of application: _____
e. Basis of your claim: _____
f. Was claim denied? ☐ Yes ☐ No

g. To what agency or company did you submit your application?

_____

h. Claim/docket number, if applicable: _____

a. Type of application: _____
b. Date (or year) of application: _____
c. Nature of claimed injury/disability: _____

d. Outcome of application: _____

e. Basis of your claim: _____

f. Was claim denied? ☐ Yes ☐ No

g. To what agency or company did you submit your application?

_____

h. Claim/docket number, if applicable: _____

a. Type of application: _____

b. Date (or year) of application: _____

c. Nature of claimed injury/disability: _____

d. Outcome of application: _____

e. Basis of your claim: _____

f. Was claim denied? ☐ Yes ☐ No

g. To what agency or company did you submit your application?

_____

h. Claim/docket number, if applicable: _____

a. Type of application: _____

b. Date (or year) of application: _____

c. Nature of claimed injury/disability: _____

d. Outcome of application: _____

e. Basis of your claim: _____

f. Was claim denied? ☐ Yes ☐ No

g. To what agency or company did you submit your application?

_____

h. Claim/docket number, if applicable: _____

9. Have you been denied insurance (life, health, or other), in the five (5) years preceding your Essure placement through the present, for reasons relating to your health?

☐ Yes ☐ No

??

If yes, please state when the denial occurred, the name of the insurance company, and the company's reason for denial:

Date of Denial: _____

Name of Insurance Company: _____

Company's Reason for Denial: _____

Date of Denial: _____

Name of Insurance Company: _____

Company's Reason for Denial: _____

Date of Denial: _____

Name of Insurance Company: _____

Company's Reason for Denial: _____

10. Beginning five (5) years preceding your Essure placement through the present, have you ever filed a lawsuit other than the present suit, relating to any bodily injury?

☐ Yes ☐ No ??

If yes, please explain the nature of the case, the parties, the case number, where it was filed, and identify your lawyer:

Nature of the Case: _____

The Parties: _____

Case Number: _____

Where Case Was Filed: _____

Your Lawyer: _____
First Last

Nature of the Case: _____

The Parties: _____

Case Number: _____

Where Case Was Filed: _____

Your Lawyer: _____
First Last

11. From the time of your Essure placement procedure through the present, have you declared bankruptcy or still have a bankruptcy pending? ☐ Yes ☐ No ??

If yes, please state the court where you filed for bankruptcy, the date of your bankruptcy filing, and the current status:

Court Where You Filed for Bankruptcy: _____

Date of Bankruptcy Filing: _____

Current Status: _____

Court Where You Filed for Bankruptcy: _____

Date of Bankruptcy Filing: _____

Current Status: _____

Court Where You Filed for Bankruptcy: _____

Date of Bankruptcy Filing: _____

Current Status: _____

III. ESSURE DEVICE INFORMATION, PLACEMENT PROCEDURE, AND CONFIRMATION TEST

1. Identify all forms of prescription or over the counter birth control you used, within the five (5) years preceding your Essure placement through the present, and provide the information requested in the table below:

☐ N/A

Contraception or method of birth control	Dates of use	Prescribing physician name and address, if applicable	Reason(s) for use	Reason(s) you discontinued use
Condoms	?? to ??	?? ?? (First / Last) ?? ?? ??	Birth control	Other (please specify) While considering tubal ligation
Depo provera	?? to MM/DD/YYYY	?? ?? (First / Last) ?? ?? ??	Contraception	Other (please specify) While considering other sterilization methods
Left tubal ligation	MM/DD/YYY to Present	XXXX XXXX (First / Last) XXXX XXXX XXXX	No Essure implant on left side	Pregnancy or suspected pregnancy
	to	First Last		
	to	First Last		
	to	First Last		
	to	First Last		
	to	First Last		

2. Date of Essure placement procedure: ?? ?? ??

3. Essure lot number(s): ??, _____, _____
_____, _____, _____
_____, _____, _____

4. Name of physician who placed your Essure device:

XXXX XXXX
First Last

First Last

First Last

Address of physician who placed your Essure device:

Street	City	State	Zip Code
XXXX	XXXX	UNK	XXXX

5. Name and address of facility where Essure placement procedure occurred:

Name: YYYY Medical Center

Address: XXXX XXXX UNK XXXX
Street City State Zip Code

Name: _____

Address: _____
Street City State Zip Code

Name: _____

Address: _____
Street City State Zip Code

6. If you received oral information and/or reviewed written or electronic information regarding Essure prior to your Essure placement procedure, including, but not limited to, any written instructions, Instructions for Use, Patient Information Booklet or Brochure, advertisements, or other materials or information from any source, complete the table below.

*****If you are producing the written or electronic information with this PFS, you may reference the produced materials in column e and you do not need to describe the content of produced materials in column e.

☐ N/A

a. Title or type of written information reviewed	**b. Source of oral and/or written information (provide specific person and your relationship to this person, website, or other source of information)**	**c. Date you received the oral or written information**	**d. Date you reviewed the written information**	**e. Describe the content of the oral or written information***
Office visit	Dr. XXXX	?? ?? ??	?? ?? ??	Discussed risks and benefits of Essure tubal occlusion

7. Were you advised of any complications or problems that occurred at the time of your Essure placement procedure?
☑ Yes ☐ No

If yes, describe the information you received, the date, and from whom:

Information Received: Risks and benefits of Essure

Date Received: ?? ?? ??

Person Who Provided the Information: XXXX (First) XXXX (Last)

Information Received: _____

Date Received: _____

Person Who Provided the Information: _____ (First) _____ (Last)

Information Received: _____

Date Received: _____

Person Who Provided the Information: _____ (First) _____ (Last)

8. Did you undergo an Essure Confirmation Test? ☑ Yes ☐ No

If you had multiple Essure Confirmation Tests, please check this box: ☐

a. If yes, on what date? ?? ?? ?? _____

_____

_____

b. Type of test: _____ ??

_____

_____

c. Name and address of physician or healthcare provider who performed Essure Confirmation Test:

Name: ?? (First) ?? (Last)

Address: ?? (Street) ?? (City) ?? (State) (Zip Code)

Name: _____ (First) _____ (Last)

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Name: _____ (First) _____ (Last)

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

d. What were the results of your Essure Confirmation Test? Mark all that apply.

- ☐ Total Bilateral Occlusion
- ☐ Unilateral Occlusion (left tube occluded)
- ☐ Unilateral Occlusion (right tube occluded)
- ☐ Failure to Occlude (close) Fallopian Tubes
- ☐ Breakage of Essure Device
- ☐ Perforation (Fallopian Tube)
- ☐ Perforation (Uterus)
- ☐ N/A
- ☑ Perforation (Other) Please Describe: _____
- ☐ Malposition of Essure Device
- ☑ Migration of Essure Device
- ☐ Expulsion of Essure Device
- ☐ Other (please describe) _____

Please also provide the date on which you received your results.

?? ?? ?? _____

_____

_____

e. What did your healthcare provider tell you about your results?

1 coil moved, perforated or disappeared

Please also provide the name(s) of the healthcare provider(s) with whom you had the communication

?? ??
First Last

_____
First Last

_____
First Last

and date(s) of communication. ?? ?? ?? _____

_____

_____

IV. ESSURE REMOVAL / REVISION SURGERY INFORMATION

1. Have you at any time communicated with any healthcare provider concerning removal of your Essure device? ☑ Yes ☐ No

If yes, please provide the following information:

Person with whom you had such communication	Date of communication	Content of communication
XXXX First XXXX Last	?? ?? ??	Laparoscopy with treatment of possible pathology, removal of right tube and
First Last		
First Last		
First Last		
First Last		
First Last		
First Last		
First Last		
First Last		
First Last		

2. Have you had your Essure (or any part of the device) removed?

☑ Yes ☐ No

If yes, please provide the date(s) of the removal(s), the name and location of healthcare provider(s) involved in the removal, and the procedure used to remove your Essure:

Date of the removal: ?? ?? ?? _____

_____

_____

_____

_____

_____

Name of healthcare provider involved in the removal:

First	Last
XXXX	XXXX

Location of healthcare provider involved in the removal:

Street	City	State	Zip Code
XXXX	XXXX		XXXX

Procedure used to remove your Essure:

Unilateral Salpingectomy	Laparoscopy with right salpinge

3. If you had your Essure removed, did you retain the Essure device or any portion of it?

☐ Yes ☑ No ☐ N/A

If yes, identify where the removed Essure device is being retained:

_____

Did you return your Essure device or any portion of it to Conceptus or Bayer?

☐ Yes ☑ No ☐ N/A

4. Were you advised of any complications from your Essure removal procedure?

☑ Yes ☐ No ☐ N/A

If yes, provide the name of the individual(s) who advised you of complications

XXXX XXXX
First Last

_____
First Last

_____ ,
First Last

the content of the communications Laparoscopy with treatment of possible pathology, ı ,

and the date of communications: ?? ?? ??

_____

_____

5. If you <u>have not</u> had your Essure removed, are you currently planning for Essure removal?

☐ Yes ☐ No ☑ N/A

If yes, provide the anticipated or scheduled date, the healthcare provider, and the reason(s) for removal:

Anticipated or scheduled date: _____

Name of healthcare provider: _____
First Last

Reason(s) for removal: _____

V. INJURIES AND COMPLICATIONS ATTRIBUTED TO ESSURE

1. Please identify any and all injuries and/or complications in the below chart that you allege **resulted from your use of the Essure device**.

☐ Ablation	☐ Hormonal Changes Describe: _____	☐ Pregnancy (No Complications)
☐ Abnormal Bleeding (general)	☐ Hysterectomy (Full)	☑ Pregnancy (With Complications)
☐ Abnormal Bleeding (vaginal, Menorrhagia)	☐ Hysterectomy (Partial)	☐ Pregnancy (Stillbirth or Miscarriage)
☐ Allergic or Hypersensitivity Reaction Type: _____	☑ Infection (Bladder/Urinary Tract/Vaginal) Type: _____	☐ Pregnancy (Termination)
☐ Apareunia (inability to have sexual intercourse)	☐ Infection (Other) Describe: _____	☐ Psychological or Psychiatric Problems Condition: _____
☐ Autoimmune Disorder Type of disorder: _____	☐ Malposition of Essure Device Location of device: _____	☐ Rashes or Skin Conditions Type: _____
☐ Bladder or Urinary Problems or Changes	☑ Migraines / Headaches	☐ Reproductive System Disorder or Condition Type of disorder or condition: _____
☐ Blood or Heart Disorder/Condition Type: _____	☑ Migration of Essure Device Location of device: _____	☐ Salpingectomy (Bilateral removal of fallopian tubes)
☐ Death	☑ Nausea	☑ Salpingectomy (One Side removal of fallopian tube)
☐ Dental Problems	☐ Neurological Conditions or Problems Type: _____	☐ Seizures
☐ Device Breakage	☐ Nickel Allergy	☐ Tubal Ligation
☑ Dysmenorrhea (Cramping)	☐ Oophorectomy (Bilateral removal of ovaries)	☐ Surgery (Other) Type of surgery: _____

☑ Dyspareunia (painful sexual intercourse)	☐ Oophorectomy (One Side removal of ovary)	☐ Tumor / Teratoma / Cancer Type: _____
☐ Expulsion of Essure Device	☑ Pain	☐ Vaginal Discharge
☐ Failure to Occlude (close) Fallopian Tube(s)	☐ Perforation (Fallopian Tube(s))	☐ Vision/Eye Problems Type: _____
☑ Fatigue	☐ Perforation (Uterus)	☑ Weight Gain / Loss (specify which one) Weight Gain
☐ Gastrointestinal or Digestive System Condition Type: _____	☐ Perforation (Other) Please describe and state the location of the perforation: _____	☑ Other Injury(ies) or Complication(s) Please describe: Poly Cystic Ovarian Syndrome (PCOS)
☐ Hair Loss	☐ Pregnancy (Ectopic)	

2. Please fill out the table below for any of the injuries and/or complications you checked in the chart above:

*If you are producing medical records with this PFS, you may reference the specific produced medical records in column e and you do not need to describe the content of produced materials in column e. However, if the medical records do not provide a complete description of all treatment received, you must describe the additional treatment here.

a. Injury or Complication	**b. Date of onset and date of diagnosis, if applicable**	**c. Did you receive treatment? (Yes/No)**	**d. Name and address of treating physician(s) and healthcare facility(ies), if applicable**	**e. Description of treatment, if applicable***	**f. Date you first suspected injury, complication or symptom was related to Essure**	**g. Did you ever experience this injury or complication <u>before</u> the date of your Essure placement? (Yes/No)** **If "Yes," please include in your response to question VII.7.**
Infection (Bladder/l Urinary tract infection and abdominal pain in pregnancy	Onset ?? ?? ?? Diagnosis ?? ?? ??	Yes	?? ?? First Last ?? Facility ?? Street ?? ?? City State Zip Code	Given a dose of Macrobid	?? ?? ??	??

a. Injury or Complication	b. Date of onset and date of diagnosis, if applicable	c. Did you receive treatment? (Yes/No)	d. Name and address of treating physician(s) and healthcare facility(ies), if applicable	e. Description of treatment, if applicable*	f. Date you first suspected injury, complication or symptom was related to Essure	g. Did you ever experience this injury or complication <u>before</u> the date of your Essure placement? (Yes/No) If "Yes," please include in your response to question VII.7.
Pregnancy (With C Oligohydramnios, breech presentation	Onset ?? ?? ?? Diagnosis ?? ?? ??	Yes	XXXX XXXX First Last YYYY Medical Center Facility XXXX Street XXXX XXXX City State Zip Code	Cesarean delivery with bilateral tubal ligation	?? ?? ??	??
Migraines / Headac	Onset ?? ?? ?? Diagnosis ?? ?? ??	Yes	?? ?? First Last ?? Facility ?? Street ?? ?? City State Zip Code	Imitrex 50 mg oral tablet	?? ?? ??	??
Nausea Right abdominal pain with nausea	Onset ?? ?? ?? Diagnosis ?? ?? ??	Yes	XXXX XXXX First Last YYYY Hospital Facility XXXX Street XXXX XXXX City State Zip Code	Morphine injection for pain	?? ?? ??	??
Salpingectomy (On	Onset ?? ?? ?? Diagnosis ?? ?? ??	Yes	XXXX XXXX First Last YYYY Associates Facility XXXX Street XXXX XXXX City State Zip Code	Laparoscopy with right salpingectomy	?? ?? ??	No
Dysmenorrhea (Cra	Onset ?? ?? ?? Diagnosis ?? ?? ??	??	XXXX XXXX First Last YYYY Associates Facility XXXX Street XXXX XXXX City State Zip Code	??	?? ?? ??	??

a. Injury or Complication	b. Date of onset and date of diagnosis, if applicable	c. Did you receive treatment? (Yes/No)	d. Name and address of treating physician(s) and healthcare facility(ies), if applicable	e. Description of treatment, if applicable*	f. Date you first suspected injury, complication or symptom was related to Essure	g. Did you ever experience this injury or complication <u>before</u> the date of your Essure placement? (Yes/No) If "Yes," please include in your response to question VII.7.
Pain Pelvic pain, pain with ovulation	Onset ?? ?? ?? Diagnosis ?? ?? ??	??	XXXX XXXX First Last YYYY Associates Facility XXXX Street XXXX XXXX City State Zip Code	??	?? ?? ??	??
Dyspareunia (painfi	Onset ?? ?? ?? Diagnosis ?? ??	??	XXXX XXXX First Last YYYY Associates Facility XXXX Street XXXX XXXX City State Zip Code	??	?? ?? ??	??
Fatigue	Onset ?? ?? ?? Diagnosis ?? ?? ??	??	XXXX XXXX First Last XXXX Associates Facility XXXX Street XXXX XXXX City State Zip Code	??	?? ?? ??	??
Weight Gain / Loss Weight gain	Onset ?? ?? ?? Diagnosis ?? ?? ??	??	XXXX XXXX First Last YYYY Associates Facility XXXX Street XXXX XXXX City State Zip Code	??	?? ?? ??	??
Other Injury(ies) or Poly Cystic Ovarian Syndrome (PCOS) Amennorhea	Onset ?? ?? ?? Diagnosis ?? ?? ??	??	XXXX XXXX First Last YYYY Associates Facility XXXX Street XXXX XXXX City State Zip Code	??	?? ?? ??	??

a. Injury or Complication	b. Date of onset and date of diagnosis, if applicable	c. Did you receive treatment? (Yes/No)	d. Name and address of treating physician(s) and healthcare facility(ies), if applicable	e. Description of treatment, if applicable*	f. Date you first suspected injury, complication or symptom was related to Essure	g. Did you ever experience this injury or complication <u>before</u> the date of your Essure placement? (Yes/No) If "Yes," please include in your response to question VII.7.
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			

a. Injury or Complication	b. Date of onset and date of diagnosis, if applicable	c. Did you receive treatment? (Yes/No)	d. Name and address of treating physician(s) and healthcare facility(ies), if applicable	e. Description of treatment, if applicable*	f. Date you first suspected injury, complication or symptom was related to Essure	g. Did you ever experience this injury or complication <u>before</u> the date of your Essure placement? (Yes/No) If "Yes," please include in your response to question VII.7.
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			

a. Injury or Complication	b. Date of onset and date of diagnosis, if applicable	c. Did you receive treatment? (Yes/No)	d. Name and address of treating physician(s) and healthcare facility(ies), if applicable	e. Description of treatment, if applicable*	f. Date you first suspected injury, complication or symptom was related to Essure	g. Did you ever experience this injury or complication <u>before</u> the date of your Essure placement? (Yes/No) If "Yes," please include in your response to question VII.7.
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			

a. Injury or Complication	b. Date of onset and date of diagnosis, if applicable	c. Did you receive treatment? (Yes/No)	d. Name and address of treating physician(s) and healthcare facility(ies), if applicable	e. Description of treatment, if applicable*	f. Date you first suspected injury, complication or symptom was related to Essure	g. Did you ever experience this injury or complication <u>before</u> the date of your Essure placement? (Yes/No) If "Yes," please include in your response to question VII.7.
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			

a. Injury or Complication	b. Date of onset and date of diagnosis, if applicable	c. Did you receive treatment? (Yes/No)	d. Name and address of treating physician(s) and healthcare facility(ies), if applicable	e. Description of treatment, if applicable*	f. Date you first suspected injury, complication or symptom was related to Essure	g. Did you ever experience this injury or complication <u>before</u> the date of your Essure placement? (Yes/No) If "Yes," please include in your response to question VII.7.
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			

a. Injury or Complication	b. Date of onset and date of diagnosis, if applicable	c. Did you receive treatment? (Yes/No)	d. Name and address of treating physician(s) and healthcare facility(ies), if applicable	e. Description of treatment, if applicable*	f. Date you first suspected injury, complication or symptom was related to Essure	g. Did you ever experience this injury or complication <u>before</u> the date of your Essure placement? (Yes/No) If "Yes," please include in your response to question VII.7.
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			

a. Injury or Complication	b. Date of onset and date of diagnosis, if applicable	c. Did you receive treatment? (Yes/No)	d. Name and address of treating physician(s) and healthcare facility(ies), if applicable	e. Description of treatment, if applicable*	f. Date you first suspected injury, complication or symptom was related to Essure	g. Did you ever experience this injury or complication <u>before</u> the date of your Essure placement? (Yes/No) If "Yes," please include in your response to question VII.7.
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			
	Onset Diagnosis		First Last Facility Street City State Zip Code			

3. If you checked "Pain" in the chart above, please provide the location(s) of pain, the frequency of pain and intensity of the pain (*e.g.*, mild, severe, constant, infrequent):

☐ N/A

Location of Pain	**Frequency of Pain**	**Intensity of Pain**
Pelvic	??	??

4. Do you claim that Essure worsened a previously existing injury/condition?

☐ Yes ☐ No

??

If yes, provide the injury/condition, whether you had recovered from that injury/condition before your Essure placement, and if so, the date you recovered from the injury/condition:

Injury/Condition	**Recovered from Injury/Condition Before Your Essure Placement**	**Date You Recovered from the Injury/Condition**

5. If you had your Essure removed, did any of the injuries or symptoms you claim resulted from Essure decrease or resolve following Essure removal?

☐ Yes ☐ No ☐ N/A

??

If yes, identify the symptoms or injuries and describe the nature and timing of the change following removal:

Symptoms/Injuries	**Nature of the Change Following Removal**	**Timing of the Change Following Removal**

VI. ESSURE-RELATED COMMUNICATIONS

1. Have you had any communications with anyone (*e.g.*, healthcare providers, other Essure users, relatives, etc.) concerning Essure, the medical conditions you identified in Section V above or allege in your Complaint, or about this lawsuit? This request includes, but is not limited to, online communications, internet postings, comments to blogs or articles, emails, and communications through social media that you made or received.

☐ Yes ☐ No

If yes, please provide the following information regarding your communications:

*If you are producing responsive documents with the PFS that pertain to your Essure-related communications, you may reference the produced materials in column d and you do not need to provide the method of communication in column c (unless the method of communication is not apparent from the document) or describe the content of produced materials in column d.

a. Name and contact information of person you communicated with, or website URL or social media platform, if applicable	**b. Relationship to the person you communicated with, if applicable**	**c. Method of communication***	**d. Description and content of your communication(s) and date***	**e. Are you producing the responsive communication? [Yes/No]** **If not, please explain why.**
Dr. XXXX	Healthcare Provider	Office visit	??	☐ Yes ☐ No ??
Dr. XXXX	Healthcare Provider	Office visit	Preconceptual counselling, counselling and	☐ Yes ☐ No ??
Dr. XXXX	Healthcare Provider	Office visit	??	☐ Yes ☐ No ??
Dr. XXXX	Healthcare Provider	Office visit	Possible schedule laparoscopy with treatment of pathology	☐ Yes ☐ No ??
Dr. XXXX	Healthcare Provider	Office visit	??	☐ Yes ☐ No ??
Dr. XXXX	Healthcare Provider	Office visit	Enquired about nickel allergy from Essure	☐ Yes ☐ No ??
				☐ Yes ☐ No
				☐ Yes ☐ No

a. Name and contact information of person you communicated with, or website URL or social media platform, if applicable	b. Relationship to the person you communicated with, if applicable	c. Method of communication*	d. Description and content of your communication(s) and date*	e. Are you producing the responsive communication? [Yes/No] If not, please explain why.
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

a. Name and contact information of person you communicated with, or website URL or social media platform, if applicable	b. Relationship to the person you communicated with, if applicable	c. Method of communication*	d. Description and content of your communication(s) and date*	e. Are you producing the responsive communication? [Yes/No] If not, please explain why.
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

a. Name and contact information of person you communicated with, or website URL or social media platform, if applicable	b. Relationship to the person you communicated with, if applicable	c. Method of communication*	d. Description and content of your communication(s) and date*	e. Are you producing the responsive communication? [Yes/No] If not, please explain why.
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

2. If you belong to any Facebook groups, or other groups (social media or otherwise), related to Essure, whether designated "private" or otherwise, please provide the following information:

☐ N/A

??

Group name and location (*e.g.*, Facebook, in person, etc.)	Date you joined the group

Group name and location (*e.g.*, Facebook, in person, etc.)	Date you joined the group

3. Other than through your attorneys, have you had or do you believe you have had any communication, oral or written, with Defendants or their representatives (including by email, social media comment or message, or other methods) including through websites for Essure and/or signing up for an online program? ☐ Yes ☐ No

??

If yes, please provide the following information*:

* If you are producing responsive documents with this PFS that pertain to communications with Defendants, you may reference the produced materials in columns a – d.

a. Date of communication	b. Method of communication	c. Representative(s) name(s)	d. Description of communication

4. Have you made any complaints or reports, orally, electronically, in writing, or through the MedWatcher mobile application, to the U.S. Food and Drug Administration, any of the defendants, or any other entity regarding the injuries you claim were caused by Essure?

☐ Yes ☐ No

??

If yes, please provide the following*:
* If you are producing responsive documents with this PFS that pertain to complaint or reports to the FDA or Defendants, you may reference the produced materials in columns a – e.

a. Date of report or complaint	**b. Method of communication (*e.g.*, MedWatcher mobile application, email, online posting, survey, in-person, phone, written)**	**c. Intended recipient of report or complaint**	**d. Content of communication**	**e. Response date and description (if applicable)**

5. Other than through your lawyers, have you ever completed or participated in any surveys, questionnaires, or studies related to Essure or your alleged injuries?

☐ Yes ☐ No

??

If yes, provide the date(s) of participation, the person or entity responsible for the study, and the nature of your participation:

Date(s) of Participation	**Person / Entity Responsible for the Study**	**Nature of Your Participation**
	First Last	

Date(s) of Participation	Person / Entity Responsible for the Study	Nature of Your Participation
	First Last	
	First Last	
	First Last	

6. Other than as already described, have you visited any websites concerning Essure?

☐ Yes ☐ No

??

If yes, provide the name of the website and the date(s) you visited:

Date(s) Visited	Name of the Website

7. When did you first learn of lawsuits involving Essure?

??

How did you first learn of lawsuits involving Essure (*e.g.* television news story, commercial, Facebook or social media site, news, etc.):

??

VII. MEDICAL BACKGROUND

1. Current height: 5 ft. 11 in. Current weight: 255 lbs.

2. Approximate weight at the time of Essure placement: 250 lbs.

3. Have you been pregnant at any time? ☑ Yes ☐ No

   If yes, state your total number of pregnancies: 6

   If yes, state your total number of live births: 4

For each live birth, please provide the date of the birth and the name and address of the location of the birth:

☐ N/A

Date of the birth	Name and address of the location where you gave birth
?? ?? ??	?? Facility ?? ?? ??
?? ?? ??	?? Facility ?? ?? ??
	Facility
	Facility

Date of the birth	Name and address of the location where you gave birth
	Facility
	Facility
	Facility
	Facility
	Facility
	Facility
	Facility
	Facility

4. Please identify any complications you have had during any of your pregnancies, including, but not limited to, miscarriage, ectopic pregnancy, delivery complications, or delivery of a baby with birth defects:

Cervical incompetence antepartum, threatened premature labor antepartum, excessive fetal growth, dehydration with pelvic discomfort, breech presentation and oligohydramnios.

5. If you claim that you experienced unintended pregnancy following your use of Essure, provide the date on which you learned you were pregnant and how you learned you were pregnant, the name and address of the physician(s) or healthcare provider(s) who treated you during the pregnancy, and the outcome of the pregnancy:

☐ N/A

Date you learned you were pregnant	How you learned you were pregnant	Name and address of the physician/healthcare provider who treated you during the pregnancy	Outcome of pregnancy
?? ?? ??	Other (please describe): ??	XXXX XXXX First Last XXXX XXXX XXXX	Live Birth With Complications
	Other (please describe):	First Last	
	Other (please describe):	First Last	
	Other (please describe):	First Last	

Did you experience any complications of your unintended pregnancy or delivery?

☑ Yes ☐ No ☐ N/A

If yes, describe the complications you experienced (mark all that apply)

☐ Stillbirth
☐ Miscarriage
☐ Termination
☐ Ectopic Pregnancy
☐ Pre-Term Labor
☐ N/A
☐ Premature Delivery
☑ Caesarean Section
☐ Birth Defects
☑ Other (please describe)
Oligohydramnios, breech presentation

and treatment (if any) you received for the complications:

6. Do you allege that Essure caused birth defects? ☐ Yes ☐ No

??

If yes, provide the name and date of birth of the child with birth defects and describe the birth defects in detail:

Name of child	Date of birth of child	Describe the birth defects in detail
First Last		
First Last		
First Last		
First Last		

7. List any medical conditions **(to the extent not already identified in this form)** for which you underwent diagnosis or medical treatment and any other medical conditions you experienced from the five (5) years prior to your Essure placement through the present and provide the information below:

☐ N/A

Condition	Nature of Treatment (if any)	Approximate Date(s) of Treatment (if any)	Name and address of physician or other healthcare provider or facility providing treatment or diagnosis services
Kidney stones	??	??	?? First ?? Last ?? Facility ?? ?? ??
Left wrist pain	Medications	MM/DD/YYYY	XXXX First XXXX Last YYYY Hospital Facility XXXX XXXX XXXX
Corneal abrasion	Irrigation of eye	MM/DD/YYYY	XXXX First XXXX Last YYYY Hospital Facility XXXX XXXX XXXX
Acute appendicitis	Appendectomy	MM/DD/YYYY	XXXX First XXXX Last YYYY Hospital Facility XXXX XXXX XXXX

Condition	Nature of Treatment (if any)	Approximate Date(s) of Treatment (if any)	Name and address of physician or other healthcare provider or facility providing treatment or diagnosis services
			First Last Facility
			First Last Facility
			First Last Facility
			First Last Facility
			First Last Facility
			First Last Facility
			First Last Facility
			First Last Facility

Condition	Nature of Treatment (if any)	Approximate Date(s) of Treatment (if any)	Name and address of physician or other healthcare provider or facility providing treatment or diagnosis services
			First Last Facility
			First Last Facility
			First Last Facility
			First Last Facility
			First Last Facility
			First Last Facility
			First Last Facility
			First Last Facility

Condition	Nature of Treatment (if any)	Approximate Date(s) of Treatment (if any)	Name and address of physician or other healthcare provider or facility providing treatment or diagnosis services
			First Last Facility
			First Last Facility
			First Last Facility
			First Last Facility
			First Last Facility
			First Last Facility
			First Last Facility
			First Last Facility

8. For the period from five (5) years prior to your Essure placement through the present, please list any prescription medications you have taken and over the counter medications that you have taken on a regular basis or for an extended period (30 days or more) and provide the following information:

☐ N/A

Name of prescription medication or over the counter medication used on a regular basis or for an extended period (30 days or more)	**Name of the prescribing healthcare provider(s), if applicable**	**Approximate dates / years taken**	**Name, address, and phone number of pharmacy where received the medication**
Colace capsule 100mg	?? First ?? Last	MM/DD/YYYY	Name: ?? Address: ?? ?? ?? Tel.: ??
Zantac tablet 150 mg	?? First ?? Last	MM/DD/YYYY	Name: ?? Address: ?? ?? ?? Tel.: ??
Phenergan tablet 25 mg	?? First ?? Last	MM/DD/YYYY	Name: ?? Address: ?? ?? ?? Tel.: ??
Prenatal plus tablet 1 mg	?? First ?? Last	MM/DD/YYYY	Name: ?? Address: ?? ?? ?? Tel.: ??
Metformin 500 mg	XXXX First XXXX Last	MM/DD/YYYY-MM/DD/YYYY	Name: ?? Address: ?? ?? ?? Tel.: ??
Prenatal 28 mg iron-800 mcg tablet	XXXX First XXXX Last	MM/DD/YYYY	Name: CVS Pharmacy Address: XXXXX XXXX XXXX Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:

Name of prescription medication or over the counter medication used on a regular basis or for an extended period (30 days or more)	Name of the prescribing healthcare provider(s), if applicable	Approximate dates / years taken	Name, address, and phone number of pharmacy where received the medication
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:

Name of prescription medication or over the counter medication used on a regular basis or for an extended period (30 days or more)	Name of the prescribing healthcare provider(s), if applicable	Approximate dates / years taken	Name, address, and phone number of pharmacy where received the medication
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:

Name of prescription medication or over the counter medication used on a regular basis or for an extended period (30 days or more)	Name of the prescribing healthcare provider(s), if applicable	Approximate dates / years taken	Name, address, and phone number of pharmacy where received the medication
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:

Name of prescription medication or over the counter medication used on a regular basis or for an extended period (30 days or more)	Name of the prescribing healthcare provider(s), if applicable	Approximate dates / years taken	Name, address, and phone number of pharmacy where received the medication
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:

Name of prescription medication or over the counter medication used on a regular basis or for an extended period (30 days or more)	Name of the prescribing healthcare provider(s), if applicable	Approximate dates / years taken	Name, address, and phone number of pharmacy where received the medication
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:
	First Last		Name: Address: Tel.:

9. To the extent not identified above, please provide the name, address, and phone number of each pharmacy you have used for the period from five (5) years prior to your Essure placement through the present:

☐ N/A

Pharmacy Name	Pharmacy Address	Pharmacy Phone Number
CVS pharmacy	XXXX XXXX XXXX	XXXX

10. Identify each insurance carrier with whom you had health insurance coverage at any time beginning five (5) years prior to your Essure placement through the present, and please include all private insurance and public assistance if applicable:

Name of insurance company	**Policy number**	**Name of policy holder/insured (if different than you)**	**Approx. dates of coverage**
Atena (POS)	XXXXXX	XXXX First XXXX Last	MM/DD/YYYY
Hap - Alliance Health and Life (PPO)	XXXX	?? First ?? Last	MM/DD/YYYY
BCPS-MI (PPO)		First Last	
Health Plus of Michigan	XXXX	First Last	
		First Last	
		First Last	
		First Last	
		First Last	
		First Last	
		First Last	
		First Last	
		First Last	

VIII. FACT WITNESSES

Please identify all persons who you believe possess information concerning your Essure injury(ies) and current medical conditions, other than your healthcare providers, and please state their name, address and his/her/their relationship to you:

☐ N/A

Name	Address	Relationship to you
?? ?? First Last	?? ?? ??	??
First Last		
First Last		
First Last		
First Last		
First Last		
First Last		
First Last		
First Last		
First Last		
First Last		
First Last		
First Last		
First Last		
First Last		
First Last		

Name	Address	Relationship to you
First Last		
First Last		
First Last		
First Last		

IX. DOCUMENT DEMANDS

Produce all documents in your custody or possession or your attorney's custody or possession, including writings on paper or in electronic form (if you have any in your custody or possession, please indicate which ones you have and attach a copy to this form) and signed authorizations as requested herein. You have a continuing duty to provide the requested documents listed above. If, for any reason, you later discover any documents that are responsive to these requests, you must provide the newly discovered documents to your attorney.

1. A copy of all medical records and/or documents relating to the use of Essure; from any hospital or healthcare provider who treated you beginning with the five (5) years prior to Essure placement and who treated you for any disease, condition or symptom referred to in any of your responses to the questions above and concerning any condition you claim is related to the use of Essure, including, but not limited to, all imaging studies of any part of your body that relate in any manner to the diagnosis, treatment, care or management of your condition and the injuries alleged in your Complaint.

   ☐ Yes ☐ No

2. If you have been the claimant or subject of any workers' compensation, social security or other disability proceeding, all documents relating to such proceeding beginning five (5) years prior to Essure placement through the present.

   ☐ Yes ☐ No ☐ N/A

3. All documents relating to Essure obtained prior to or at the time of your Essure placement, including, but not limited to: informed consent form, Instructions for Use, patient identification card, Patient Information Booklet, other handouts or product warnings, online/newspaper/magazine articles or information; advertisements or promotions.

   ☐ Yes ☐ No

4. All documents that you or anyone acting on your behalf (other than your lawyer) obtained from Defendants or any representative of Defendants relating to Essure.

☐ Yes ☐ No ☐ N/A

5. All communications or statements (written or electronic) you have made or responded to with anyone (*e.g.*, healthcare providers, other Essure users, relatives, etc.) other than your lawyer, about Essure, this lawsuit, or your alleged injuries. This request includes, but is not limited to, online communications, internet postings, comments to blogs or articles, emails, and communications through social media that you have made or received. If you posted concerning Essure on any social media, provide your history from that site (*e.g.*, provide a print out of your "Download your info" report from Facebook, if you discussed Essure on Facebook).

☐ Yes ☐ No ☐ N/A

6. Copies of letters testamentary or letters of administration relating to your status as Plaintiff (if applicable).

☐ Yes ☐ No ☐ N/A

7. Decedent's death certificate and autopsy report (if applicable).

☐ Yes ☐ No ☐ N/A

X. AUTHORIZATIONS

A. Provide ONE (1) SIGNED ORIGINAL copy of "AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION PURSUANT TO HIPAA (45 CFR Parts 160 and 164)" for **each healthcare provider/facility/pharmacy** identified in the Plaintiff Fact Sheet.

B. If you responded "YES" to Section II. Q.8 (Workers' Compensation), provide ONE (1) SIGNED ORIGINAL copy of "AUTHORIZATION FOR THE USE AND DISCLOSURE OF WORKERS' COMPENSATION INFORMATION."

C. If you identified any insurance companies in this Plaintiff Fact Sheet, provide ONE (1) SIGNED ORIGINAL copy of "AUTHORIZATION FOR THE USE AND DISCLOSURE OF INSURANCE INFORMATION" for **each insurance company** identified.

D. If you indicated in Section V. Q1. that you suffered a Psychological or Psychiatric Problem as a RESULT of Essure, provide ONE (1) SIGNED ORIGINAL copy of "AUTHORIZATION TO DISCLOSE PSYCHIATRIC RECORDS AND PSYCHOTHERAPY NOTES INFORMATION PURSUANT TO HIPAA (45 CFR Parts 160 and 164)" for **each healthcare provider** who diagnosed or treated you for that Psychological or Psychiatric Problem.

VERIFICATION

Pursuant to California Code of Civil Procedure §2015.5 or other applicable law or rule, I declare under penalty of perjury under the laws of the State of California 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, that I have supplied all the documents requested in Part IX of this Plaintiff Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied the authorizations attached to this declaration.

Further, by signing below, I waive notice under the California Code of Civil Procedure (including, but not limited to, Code of Civil Procedure § 1895.3), or other applicable law or rule, of subpoenas or other requests for production of personal records directed to health care providers, insurers, and others for whom I have provided Authorizations in connection with this Plaintiff Fact Sheet.

Date:_____ _____

Signature of Plaintiff

Name of Plaintiff: _____