UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

IN RE: BENICAR (OLMESARTAN) PRODUCTS LIABILITY LITIGATION	MDL No. 2606
This Document Relates To: MDL Case No. _____	Plaintiff: _____

PLAINTIFF'S FACT SHEET

This Fact Sheet must be completed by each plaintiff who has filed a lawsuit related to the use of Benicar®, Benicar HCT®, Azor® or Tribenzor® by the plaintiff. Please answer every question to the best of your knowledge. In completing this 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 in any material respect. For each question, where the space provided does not allow for a complete answer, please attach additional sheets so that all answers are complete. When attaching additional sheets, clearly label what question your answer pertains to.

In filling out this form, please use the following definitions: (1) "**health care provider**" means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, 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 the plaintiff or plaintiff's decedent; (2) "**document**" means any writing or record 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, and x-rays, drawings, graphs, phone-records, non-identical copies, and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form; (3) "Olmesartan Product" means Benicar, Benicar HCT, Azor, Tribenzor.

Information provided by plaintiff will only be used for purposes related to this litigation. This Fact Sheet is completed pursuant to the Federal Rules of Civil Procedure governing discovery (or, for state court case, the governing rules of the state in which the case is pending).

I. CORE CASE INFORMATION

A. Please provide the following information for the civil action which you filed:

Caption:	
Court and Docket No.	
Plaintiff's Attorney:	

B. Please provide the following information for the individual on whose behalf this action was filed and, if the case was filed in a representative capacity, for the named plaintiff, and for any spouse plaintiff:

Name:		Social Security Number :	
Address:		Date of Birth:	

C. Please provide the following information regarding usage of Benicar®, Benicar HCT®, Azor®, or Tribenzor®.

YOU MUST ATTACH COPIES OF PRESCRIPTION AND/OR PHARMACY RECORDS DEMONSTRATING PRODUCT USE.

Identify Product

Benicar _____

Benicar HCT _____

Azor _____

Tribenzor _____

Set forth for each:

Dosage:	
Dates of Use:	
Reason for Prescription:	
Name and Address of Prescribing Physician(s)	
Name and Address of Pharmac(ies):	

D. Do you allege sprue-like enteropathy?

Yes: _____ No: _____

If you answered "yes" attach contemporaneous medical records showing the diagnosis of sprue-like enteropathy.

If you answered "no" attach contemporaneous medical records showing the diagnosis of the injury claimed.

YOU MUST ATTACH MEDICAL RECORDS DEMONSTRATING ALLEGED INJURY

Please specify:

Date of Diagnosis:			
Name and Address of Diagnosing Physician(s):			
Hospitalized?	Y/N	Date(s) of Hospitalization(s):	
Reason for Hospitalization(s):			

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

Name:	
Address:	
Capacity in which you are representing the individual:	
If you were appointed as a representative by a court, state the State, Court and Case Number:	
Relationship to the Represented Person:	
State the date and place of death of the decedent (if applicable)	

If you are completing this questionnaire in a representative capacity, please respond to the remaining questions with respect to the person whose medical treatment involved the use of Benicar®, Benicar HCT®, Azor® or Tribenzor®. Those questions using the term "You" refer to the person whose treatment involved the use of Benicar®, Benicar HCT®, Azor® or Tribenzor®. If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.

II. PERSONAL INFORMATION

A. Background Information

1. Name: _____

2. Maiden or other names you have used or by which you have been known: _____
_____

3. Social Security Number: _____

4. Medicare Health Insurance Claim Number (if applicable): _____

5. Current address and date when you began living at this address: _____
_____
_____

6. Identify each address at which you have resided during the last ten (10) years and the approximate dates during which you lived at each address (most recent first):

Street Address	City, State, Zip	Dates Resided	
		From	To

7. Date and Place of Birth: _____

8. Sex: Male: _____ Female: _____

9. Do you have a driver's license? Yes: _____ No: _____

B. Family Information

1. Have you ever been married? Yes: _____ No: _____

If yes, for each spouse, state the spouse's name, the date of marriage, the date the marriage ended, the nature of termination (*e.g.*, death, divorce, etc.), and that spouse's present address:

Spouse's Name	Date of Marriage	Date Marriage Ended	Nature of Termination	Spouse's Present Address

2. Has your spouse filed a loss of consortium or other claim in this lawsuit?

   Yes: _____ No: _____

3. If you have children, please identify each child's name, address and date of birth:

Child's Name	Address	Date of Birth

C. Educational History

1. Identify each high school, vocational school, college, university or other post-secondary educational institution you attended, the institution's address, the dates of attendance, and the diplomas or degrees awarded:

Name of School	Address	Dates of Attendance	Diploma/Degree Awarded

D. Employment History

Whether or not you are making a lost wage claim, please respond to all questions in this section except as noted:

1. Are you currently employed? Yes: _____ No: _____

If yes, identify your current employer with name, address and telephone number and your position there: _____

_____

_____

a. Have you ever left this job for a medical reason? Yes: _____ No: _____

If yes, describe why you left: _____

_____

2. Please identify each of your employers over the past ten (10) years, including the dates of such employment and positions held (most recent first). If you were self-employed during the relevant time, please also include the relevant information (you only need to supply rate of pay if you are making a lost wage claim in this lawsuit):

Employer	Address	Type of Business & Position	Dates of Employment	Pay Rate

3. Have you been out of work for more than thirty (30) days for reasons related to your health in the past ten (10) years? Yes: _____ No: _____

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

_____

_____

E. Military Service

1. Have you ever served in any branch of the military? Yes: _____ No: _____

If yes, Branch and dates of service:

_____

If yes, were you discharged for any reason relating to your health (whether physical, psychiatric, or other health condition)? Yes: _____ No: _____

If yes, state the condition:

_____

2. Have you ever been rejected from military service for any reason relating to your health (whether physical, psychiatric, or other health condition)?

Yes: _____ No: _____

If yes, state the condition:

_____

F. Worker's Compensation and Disability Claims: Have you ever filed for worker's compensation, social security and/or state or federal disability benefits related to any gastrointestinal issues or your ingestion of any Olmesartan products?

Yes: _____ No: _____

If yes, please then as to each application, separately state the following:

Year claim was filed: _____

Where claim was filed: _____

Claim/docket number, if applicable: _____

To what agency or company did you submit your application:_____

Nature of claimed injury: _____

Period of disability: _____

Amount awarded: _____

Was claim denied? Yes:_____ No:_____

[Attach additional sheets as necessary to describe more than one claim.]

G. Life Insurance: Within the last ten (10) years, have you ever been denied life insurance based on health reasons? Yes: _____ No: _____

If yes, please state when, the name of the life insurance company, and the company's stated reason for denial (if any):

_____

_____

H. Other Lawsuits: Have you ever filed a lawsuit or made a legal claim of any type, *other than* in the present suit? Yes: _____ No: _____

If yes, state: (1) nature of the case (2) the state and county in which claim was filed, (3) the caption, case name and/or names of adverse parties, (4) the civil action or docket number assigned to each such claim, action or suit, (5) attorney who represented you, and (6) the current status of the claim.

_____

_____

_____

I. Convictions: Have you ever been convicted of, or pled guilty (or no contest) to, a felony and/or a crime involving fraud or dishonesty?

Yes: _____ No: _____

If yes, please describe: (1) the crime or offense, (2) the state and county in which you were convicted or pled guilty, (3) the date on which you were convicted or pled guilty, and (4) the sentence or other outcome.

_____

_____

_____

J. Computer Use: Have you had access to a computer at any time during the past five (5) years? Yes: _____ No: _____

If yes, then answer the following:

1. Did you visit within the past five years any website containing information regarding Benicar®, Benicar HCT®, Azor® and/or Tribenzor®, other Angiotensin II Receptor Blockers (ARBs), hypertension, intestinal disease, sprue-like enteropathy, and/or colitis?

   Yes: _____ No: _____

   If yes, identify the websites and the dates viewed:

_____

_____

_____

2. Did you communicate in the past ten (10) years via email, visit any chat rooms, or publicly post a comment, message or blog entry on a public internet site regarding your health, Benicar®, Benicar HCT®, Azor® and/or Tribenzor®, other ARBs, hypertension, intestinal disease, sprue-like enteropathy and/or colitis? (You should include all postings on public social network sites including Twitter, Facebook, MySpace, LinkedIn, or "blogs" where the general public may post such comments).

   Yes: _____ No: _____ Do Not Recall: _____

   If yes, please tell us where and when you made such public posts and the substance of what was posted.

_____

K. Bankruptcy: Have you or your spouse ever filed for bankruptcy?

Yes: _____ No: _____

If yes, please state when and in what court you filed your bankruptcy petition, including the docket number of the petition and the orders of discharge:

_____

III. CLAIM INFORMATION

A. Hypertension

1. Relevant History

a. When were you first diagnosed with hypertension?

_____

_____

b. Prior to taking Benicar®, Benicar HCT®, Azor® and/or Tribenzor®, how did you manage or treat hypertension (describe - if applicable)?

_____

_____

c. If you discontinued the Olmesartan Products, how have you managed or treated your hypertension?

_____

_____

d. In the chart below, please identify all healthcare providers who treated you for hypertension:

Name of health care provider(s)	Address, City, State and Zip

B. Olmesartan

1. Set forth all medical conditions for which you have taken Benicar®, Benicar HCT®, Azor® and/or Tribenzor®, dates and identify all prescribers (attach additional sheets as necessary).

Condition and	Address, City, State and Zip

Name of health care provider(s)	

2. Are you currently taking Benicar®, Benicar HCT®, Azor® and/or Tribenzor®?

Yes: _____ No: _____

3. Provide below the name and address of the pharmacy(ies) or other store(s), mail order entity or location(s) from which you obtained Benicar®, Benicar HCT®, Azor® and/or Tribenzor® (if samples were provided, see No. 4 below):

Name of Pharmacy or other Store/Location	Address, City, State and Zip

4. Have you ever received any samples of Benicar®, Benicar HCT®, Azor® and/or Tribenzor®?

Yes: _____ No: _____ Do Not Recall: _____

If yes, please state the following: (1) who gave you the sample(s); (2) when the sample(s) were provided; and (3) how many sample(s) you received:

_____

_____

5. Were you ever given any written instructions, including any prescriptions, packaging, package inserts, literature, medication guides, or dosing instructions, regarding Benicar®, Benicar HCT®, Azor® and/or Tribenzor®?

Yes: _____ No: _____ Do Not Recall: _____

If yes, please describe the documents if you no longer have them. If you have the documents, please produce them or make them available for inspection.

_____

_____

6. Were you given any oral instructions regarding your use of Benicar®, Benicar HCT®, Azor® and/or Tribenzor®?

Yes: _____ No: _____ Do Not Recall: _____

If yes, please identify each person who gave you oral instructions about Benicar®, Benicar HCT®, Azor® and/or Tribenzor® and describe what he or she told you:

_____

_____

7. Do you have in your possession, or does your attorney have, the packaging from the Benicar®, Benicar HCT®, Azor® and/or Tribenzor® you allege to have used? Yes: _____ No: _____

   If yes, who currently has custody of the Benicar®, Benicar HCT®, Azor® and/or Tribenzor® packaging?

   _____

8. Have you ever seen any advertisements (*e.g.*, in magazines or television commercials) for Benicar®, Benicar HCT®, Azor® and/or Tribenzor®?

   Yes: _____ No: _____

   If yes, identify the advertisement or commercial, state the nature and content of each advertisement or commercial, and approximately when you saw the advertisement or commercial: _____

   _____

   _____

9. Other than through your attorneys, have you had any communication, oral or written, with any of the Defendants or their representatives?

   Yes: _____ No: _____ Do Not Recall: _____

   If yes, please identify:

   Date of Communication: _____ Method of Communication: _____

   Name of Representative: _____

   Substance of communication between you and any representative(s) of the Defendants: _____

   _____

C. For each injury claimed, please provide the following information:

1. Describe the nature of your injury, illness, or disability:

   _____

   _____

   _____

   _____

   When did this/these injury(ies) occur?

   _____

   _____

   Have you ever been hospitalized as a result of any of this/these injury(ies)?

   If yes, please provide the following information:

i. Approximate date(s) of hospital admission:_____

ii. Approximate date(s) of discharge: _____

iii. Hospital name(s) and address(es):_____

2. Procedures and/or Treatments.

a. Identify the primary treating physician(s) for the injuries you claim in this case:

_____

_____

Medications Prescribed: _____

Did you receive any treatment other than medication? Yes: _____ No: _____

b. Have you ever undergone any of the following treatments and/or procedures in the last 10 years?

Treatment/Procedure	Yes	No	Don't Know	Date of Treatment/Procedure
Endoscopy				
Colonoscopy				
Gastrointestinal Surgery				
Colectomy				
Total Parenteral Nutrition				
Gluten-Free Diet				
Peripherally Inserted Central Catheter (PICC) Line				

c. For each treatment and/or procedure for which you answered Yes in the previous chart, please provide the information requested below:

Name of health care provider(s)	Address, City, State and Zip

3. Were you treated by any healthcare provider or at any hospital for this/these injury(ies) who is not identified in the Core Case Information section above?

Yes: _____ No: _____

If yes, please provide the following information:

Name of health care provider and Hospital	Address, City, State and Zip	Approx. date(s) of treatment

4. At the time you experienced the injury(ies) you attribute to your use of Benicar®, Benicar HCT®, Azor® and/or Tribenzor®, were you undergoing treatment for any other medical conditions? If so, describe the condition, the treatment, and identify the healthcare providers treating you.

_____

_____

5. At the time you experienced the injury(ies) you attribute to your use of Benicar®, Benicar HCT®, Azor® and/or Tribenzor® what other prescription and over the counter medications were you taking?

_____

_____

D. Does any injury, illness, or disability you attribute to the Olmesartan Products persist today? Yes: _____ No: _____

If yes, identify the current symptoms, the medication or treatment you continue to receive, the health care provider(s) providing treatment, and that health care provider's address:

Current symptoms: _____

Medications currently taking: _____

Other treatment currently receiving: _____

Treating provider: _____

Address: _____

_____

E. Allergies and Allergic Reactions.

1. Have you ever experienced an allergic reaction to any food or medication?

If yes, please state:

Food or Medication	When Allergy Diagnosed	Symptoms of Allergy	Healthcare Provider who Diagnosed Allergy	Treatment Received, if any

F. Are you claiming mental and/or emotional injury as a result of the use of Benicar®, Benicar HCT®, Azor® and/or Tribenzor®?

Yes: _____ No: _____

1. *If yes*, what mental and/or emotional injury do you claim resulted from the use of Benicar®, Benicar HCT®, Azor® and/or Tribenzor®?

_____

_____

2. *If yes*, for each healthcare provider (including but not limited to primary care physicians, psychiatrists, psychologists, and/or counselors) from whom you have sought treatment for psychological, psychiatric, or emotional problems as a result of Benicar®, Benicar HCT®, Azor® and/or Tribenzor®, state the following:

Name	Address	Condition Treated	Date Treated	Medications Prescribed

G. Lost Wages: Do you claim that you lost wages or suffered impairment of earning capacity as a result of any condition you allege was caused by Benicar®, Benicar HCT®, Azor® and/or Tribenzor®?

Yes: _____ No: _____

1. *If yes*, state the years involved, and the total amount of time you have lost from work as a result of any condition you claim was caused by Benicar®, Benicar HCT®, Azor® and/or Tribenzor®.

_____

2. State the annual gross income you derived from your employment for each of the five (5) years prior to the injury or condition you claim was caused by Benicar®, Benicar HCT®, Azor® and/or Tribenzor®.

Year	Annual gross income

3. State the annual gross income for every year following the injury or condition you claim was caused by Benicar®, Benicar HCT®, Azor® and/or Tribenzor®.

Year	Annual gross income

4. State the amount of income you claim you lost as a result of any condition you claim was caused by Benicar®, Benicar HCT®, Azor® and/or Tribenzor®:

$_____

H. Medical Expenses: Please list all of your medical expenses, including amounts billed or paid by insurers and other third-party payors, which are related to any condition which you claim was caused by Benicar®, Benicar HCT®, Azor® and/or Tribenzor® for which you seek recovery in the action which you have filed.

Provider	Date	Expense

I. Have you had any discussions with any doctor or other healthcare provider about whether Benicar®, Benicar HCT®, Azor® and/or Tribenzor® caused or contributed to your injury?

Yes: _____ No: _____ Do Not Recall: _____

If yes, please identify:

Name of health care provider: _____

Address: _____

Date of discussion: _____

What were you told? (Describe discussion regarding Benicar®, Benicar HCT®, Azor® and/or Tribenzor®):

_____

_____

[If discussed with more than one doctor, please answer for each doctor, using additional pages as necessary.]

IV. LIST OF HEALTHCARE PROVIDERS

A. Healthcare Providers (Excluding Mental Health Care Providers): Identify each physician, doctor, or other health care provider who has provided treatment to you for any reason in the past ten (10) years and the reason for consulting the health care provider or mental health care provider (attach additional sheets as necessary).

Name	Address	Approximate Dates	Reason for Consultation

B. Hospitals, Clinics, and Other Facilities: Identify each hospital, clinic, surgery center, physical therapy or rehabilitation center, or other healthcare facility where you have received inpatient or outpatient treatment (including emergency room treatment) that you attribute to the injuries claimed herein (attach additional sheets as necessary):

Name	Address	Approximate Dates	Reason for Treatment

C. Pharmacies: Identify each pharmacy, drugstore, and/or other supplier (including mail order) where you have had prescriptions filled or from which you have ever received any prescription medication in the past ten (10) years (attach additional sheets as necessary):

Name of Pharmacy	Address of Pharmacy	Approximate Dates

D. Insurance Carriers: Identify each health insurance carrier which provided you with medical coverage and/or pharmacy benefits for the last ten (10) years, and the policy number (attach additional sheets as necessary).

Carrier	Policy Number	Approximate Dates of Coverage

E. Other Witnesses: Other than those previously identified, please identify all persons who you believe possess information concerning your injury and/or your current medical condition. For each person, please state their name, address, phone number, relationship to you, and the information you believe they possess (attach additional sheets as necessary)

Name	Address and Phone Number	Relationship	Information you believe they possess

V. MEDICAL BACKGROUND

A. Height and weight at the time your alleged injury began: Height: _____ Weight: _____

B. Height and weight at the time your alleged injury ended: Height: _____ Weight: _____

C. Current Weight: _____

D. Tobacco Use History:

Did you use tobacco, including cigarettes, cigars, pipes, and/or chewing tobacco/snuff at any time during the period you were taking any Olmesartan product?

Yes: _____ No: _____

If yes, please identify the types of tobacco used and the amount used.

Types of tobacco used: ___ cigarettes ___ cigars

___ pipes ___ chewing tobacco/snuff

Date tobacco use started: _____ Date tobacco use ceased: _____

Amount used: on average, _____ per day for ___ years

E. Alcohol Use History

Do you currently or have you in the past drank alcohol (beer, wine, whiskey, etc.)?

Yes: _____ No: _____

If yes, please check which of the following represents your typical alcohol consumption in the six (6) months leading up the date on which you first experienced any symptoms you believe are related to your alleged injury(ies):

_____ 1–2 drinks per week

_____ 3–6 drinks per week

_____ 7–10 drinks per week

_____ 10 or more drinks per week

_____ Other - explain: _____

If yes, please check which of the following represents your typical alcohol consumption over the past ten (10) years:

_____ 1–2 drinks per week

_____ 3–6 drinks per week

_____ 7–10 drinks per week

_____ 10 or more drinks per week

_____ Other - explain: _____

Type of Alcohol Consumed: _____

F. Other Drug Use

1. Have you used cocaine, ecstasy, heroin, and/or methamphetamines from five years before your first use of any Olmesartan medication up to the present?

Yes: _____ No: _____

2. Did you use any of the above drugs during the time period you were taking Benicar®, Benicar HCT®, Azor® and/or Tribenzor®?

   Yes: _____ No: _____

G. Have you been diagnosed with, or treated for any of the following in the past ten (10) years? If so, for each condition for which you answer yes, please provide the additional information requested below:

Condition	Yes	No	Unknown
Alcoholism			
Autoimmune disease or condition (Including, but not limited to, Crohn's disease, lupus, rheumatoid arthritis, psoriasis, scleroderma, or mixed-connective tissue disorder)			
Cancer of any type (Including, but not limited to lung, colon, liver, breast, kidney, stomach, testicular, leukemia, Hodgkin's disease, or Non-Hodgkin's lymphoma)			
Celiac Disease			
Colitis			
Collagenous colitis			
Collagenous sprue			
Common variable immunodeficiency (CVID)			
Constipation			
Crohn's Disease			
Deep Vein Thrombosis (DVT)			
Depression/Anxiety			
Dermatitis herpetiformis			
Diabetes			
Diarrhea			
Diverticulitis			
Dizziness			
Fructose intolerance			
Gallbladder disease			

Condition	Yes	No	Unknown
Gastrointestinal bleeding			
Giardiasis			
Glandular disease (Including, but not limited to, malfunction of the pancreas, parathyroid, thyroid, adrenal gland, or pituitary gland)			
Gluten sensitivity			
Gluten intolerance			
Hepatic dysfunction or active liver disease			
Hypertension (High Blood Pressure)			
Hypotension (Low Blood Pressure)			
Intestinal obstruction			
Increased C-Reactive Protein (CRP) levels			
Infectious disease such as tuberculosis, pneumonia, rheumatic fever, syphilis, gonorrhea, typhoid fever, encephalitis, poliomyelitis, malaria, or hepatitis			
Inflammatory Bowel Disease			
Iritis			
Irritable Bowel Syndrome			
Jaundice			
Kidney Problems (disease, infections, stones, protein in urine, etc.)			
Lactose intolerance			
Liver dysfunction			
Liver tumor			
Lymphocytic colitis			
Malabsorption			
Malnutrition			
Microscopic colitis			
Nausea			
Pancreatic insufficiency			
Protein-losing enteropathy			
Pulmonary Embolism / blood clot in lung			

Condition	Yes	No	Unknown
Refractory celiac disease			
Refractory sprue			
Renal Insufficiency			
Retinal bleed			
Shortness of breath			
Small intestinal bacterial overgrowth			
Stomach ulcers/Peptic ulcers			
Stroke of any type (hemorrhagic, ischemic, etc.)			
Thrombosis			
Transient Ischemic Attack (TIA)			
Tropical sprue			
Ulcerative Colitis			
Unexpected weight loss			
Villous atrophy			
Vomiting			

K. For each condition for which you answered yes in the previous chart, please provide the information requested below (attach additional sheets as necessary)

Condition	Name, Address of Treating Health Care Provider	Approximate Date of Onset	Treatment Received and Outcome

VI. MEDICATIONS

A. List all of the medications (prescription and over the counter) you currently take, and attach additional sheets as necessary:

Medication	Dose/Frequency/Dates of Use	Physician Ordering	Pharmacy Dispensing	Purpose

B. Do you currently take, or did you take in the ten (10) years prior to when you first took Benicar®, Benicar HCT®, Azor® and/or Tribenzor®, any of the following antihypertensive medications:

Drug Class	Medication	Dose/Frequency/ Dates of Use	Physician	Reason for Use	Reason for Discontinuation	Adverse Effects, if any
	chlorothiazide (Diuril®)					
	hydrochlorothiazide (Ezide®, Esidrix®, Aquazide-25®, Aquazide-H®, Microzide®, Oretic®)					
	methyclothiazide					
	trichlormethiazide					
	chlorthalidone					

Drug Class	Medication	Dose/Frequency/ Dates of Use	Physician	Reason for Use	Reason for Discontinuation	Adverse Effects, if any
Diuretics	(Thalitone®)					
	indapamide (Lozol®)					
	metolazone (Mykrox®, Zaroxolyn®)					
	polythiazide (Renese®)					
	bumetanide (Bumex®)					
	ethacrynic acid (Edecrin®)					
	furosemide (Lasix®)					
	torsemide (Demadex®)					
	amiloride hydrochloride (Midamor®)					
	spironolactone (Aldactone®)					
	eplerenone (Inspra®)					
	triamterene (Dyrenium®)					
Alpha Blockers	doxazosin (Cardura®)					
	prazosin (Minipress®)					
	terazosin (Hytrin®)					
Central alpha-2 agonists and centrally acting	clonidine (Catapres®)					
	clonidine patch (Catapres® TTS)					
	methyldopa (Aldomet®)					

Drug Class	Medication	Dose/Frequency/ Dates of Use	Physician	Reason for Use	Reason for Discontinuation	Adverse Effects, if any
medicines	guanfacine (Tenex®)					
Beta Blockers	acebutolol (Sectral®)					
	atenolol (Tenormin®)					
	betaxolol (Kerlone®)					
	bisoprolol fumarate (Zebeta®)					
	carteolol (Cartrol®)					
	esmolol (Brevibloc®)					
	metoprolol tartrate (Lopressor®)					
	metoprolol succinate extended release (Toprol-XL®)					
	nadolol (Corgard®)					
	nebivolol (Bystolic®)					
	penbutolol sulfate (Levatol®)					
	pindolol (Visken®)					
	propranolol hydrochloride (Inderal®; long acting, Inderal® LA)					
	timolol (Blocadren®)					
Alpha-beta Blockers	carvedilol (Coreg®)					
	labetalol (Normodyne®, Trandate®)					
	amlodipine besylate					

Drug Class	Medication	Dose/Frequency/ Dates of Use	Physician	Reason for Use	Reason for Discontinuation	Adverse Effects, if any
Calcium Channel Blockers	(Norvasc®)					
	diltiazem extended release (Cardizem® CD, Cardizem® LA, Dilacor XR®, Tiazac®)					
	felodipine (Plendil®)					
	isradipine (DynaCirc® CR)					
	nicardipine (Cardene®)					
	nifedipine long acting (Procardia® XL, Adalat® CC)					
	nisoldipine (Sular®)					
	verapamil (Calan®, Isoptin®)					
	verapamil controlled onset (Covera HS®, Verelan® PM)					
ACE Inhibitors	benazepril (Lotensin®)					
	captopril (Capoten®)					
	enalapril (Vasotec®)					
	fosinopril (Monopril®)					
	lisinopril (Prinivil®, Zestril®)					
	moexipril (Univasc®)					
	perindopril (Aceon®)					
	quinapril					

Drug Class	Medication	Dose/Frequency/ Dates of Use	Physician	Reason for Use	Reason for Discontinuation	Adverse Effects, if any
	(Accupril®)					
	ramipril (Altace®)					
	trandolapril (Mavik®)					
ARBs	candesartan cilexetil (Atacand®)					
	eprosartan mesylate (Teveten®)					
	irbesartan (Avapro®)					
	losartan potassium (Cozaar®)					
	telmisartan (Micardis®)					
	valsartan (Diovan®)					
	azilsartan medoxomil (Edarbi®)					
Direct Renin Inhibitors	aliskiren (Tekturna®)					

Other hypertension therapy:

Describe hypertension therapy: _____

_____

Date Prescribed: _____ Dosage Prescribed: _____

Date(s) Used: _____ Dosage Used: _____

Reason for use: _____

_____

Adverse effects (if any): _____

_____

Reason for discontinuation: _____

_____

Name of prescriber: _____

C. Do you currently take, or did you take in the ten (10) years prior to when you first took Benicar®, Benicar HCT®, Azor® and/or Tribenzor®, any of the following medications:

Name of Medication	Yes	No	Unknown
AcipHex (rabeprazole)			
Carbatrol (carbamazepine)			
Clozaril (clozapine)			
CellCept (mycophenolate mofetil)			
Comtan (entacapone)			
Dexilant (dexlansoprazole)			
Epitol (carbamazepine)			
Eulexin (iutamide)			
Equetro (carbamazepine)			
FazaClo (clozapine)			
Imuran (azathioprine)			
Ipilim			
Kapidex (dexlansoprazole)			
Navelbine (vinorelbine)			
Nexium (esomeprazole)			
Nonsteroidal anti-inflammatory drugs (NSAIDs) (including, but not limited to, aspirin, ibuprofen and naproxen)			
Paxil (paroxetine)			
Pexeva (paroxetine)			
Prandase (acarbose)			
Prescose (acarbose)			
Prevacid (iansoprazole)			
Prilosec (omeprazole)			
Protonix (pantoprazole)			
Tegretol (carbamazepine)			
Trexall (methotrexate)			
Tritec (ranitidine)			

Name of Medication	Yes	No	Unknown
Yervoy (ipilumab)			
Zantac (ranitidine)			
Zestril (Lisinopril)			
Zocor (simvastatin)			

1. For each medication for which you answered yes in the previous chart, please provide the information requested below (attach additional sheets as necessary):

Name of Medication/Drug Used	Name, Address, and Telephone Number of Prescribing Health Care Provider	Approximate Dates of Use	Purpose

D. Are there any prescription medications (other than the Olmesartan Products) that you have taken on a regular basis (more than three (3) months) in the past ten (10) years? Yes: _____ No: _____

If yes, please provide the following information for each prescription:

Name of Prescription Medication	Healthcare provider(s) that prescribed the medication	Approximate dates/years taken	Reason for prescription

Name of Prescription Medication	Healthcare provider(s) that prescribed the medication	Approximate dates/years taken	Reason for prescription

E. For the one year period before the onset of the injuries for which recovery is sought in this action, set forth: (a) the name of each and every over the counter or prescription drug product ingested or otherwise used by you (including all vitamins, nutritional supplements, and all herbal and homeopathic medications and remedies); (b) the date of each ingestion or use; (c) the dosage ingested and frequency of use; (d) the purpose for using each such product; (e) the prescribing physician (if any); (f) the pharmacy or store where the product was purchased; and (g) the date of purchase. Attach additional sheets as necessary.

Name of over-the-counter or prescription drug	Dosage ingested or used and frequency	Purpose of use	Prescribing health care provider (if any)	Pharmacy or store where purchased	Date of Purchase

VII. FAMILY MEDICAL HISTORY

A. Please indicate, to the best of your knowledge, whether your parents, siblings, or grandparents have ever had any of the following:

Condition	Yes	No	Unknown

Condition	Yes	No	Unknown
Autoimmune disease or condition (Including, but not limited to, Crohn's disease, lupus, rheumatoid arthritis, psoriasis, scleroderma, or mixed-connective tissue disorder)			
Celiac Disease			
Colitis			
Collagenous colitis			
Collagenous sprue			
Crohn's Disease			
Gastrointestinal bleeding			
Giardiasis within the last 7 years			
Gluten sensitivity			
Gluten intolerance			
Hypertension (High Blood Pressure)			
Hypotension (Low Blood Pressure)			
Inflammatory Bowel Disease			
Irritable Bowel Syndrome			
If you claim kidney problems as an issue in this lawsuit.			
Lactose intolerance			
Liver dysfunction			
Lymphocytic colitis			
Malabsorption			
Malnutrition			
Microscopic colitis			
Protein-losing enteropathy			
Refractory celiac disease			
Refractory sprue			
If you claim kidney problems as an issue in this lawsuit.			
Tropical sprue			
Ulcerative Colitis			
Villous atrophy			

1. For each condition which you answered yes in the previous chart, please provide the information requested below (attach additional sheets as necessary):

Condition	Family Member's Name and Address	Family Member's Relationship to You	Treatment and Outcome (if known)

VIII. FRAUD CLAIMS

1. Are you claiming fraud or consumer fraud in this action?

   Yes: _____ No: _____

   If yes, please answer the following questions:

2. What representation(s) do you claim was fraudulently made and to whom was it made?

3. By whom?

4. When was the alleged representation(s) made? Identify approximate date(s).

5. What was the substance and nature of the alleged representation(s). Explain with specificity.

IX. DECEASED INDIVIDUALS AND AUTOPSY INFORMATION

A. Are you filling this out on behalf of an individual who is deceased?

   Yes: _____ No: _____

If yes, please state the following from the Death Certificate of the individual, and attach a copy of the letter of administration.

(NOTE: In lieu of the following, please attach a copy of the death certificate.)

Date of death: _____

Place of death: _____

Facility or location where death occurred: _____

Name of physician who signed death certificate: _____

Cause of death: _____

B. Are you filling this out on behalf of an individual who is deceased and on whom an autopsy was performed?

Yes: _____ No: _____

If yes, please attach a copy of the autopsy report.

X. DOCUMENT DEMANDS

A. AUTHORIZATIONS [To be served within twenty (20) days after service of the PFS]

1. Health Care Authorizations – For each health care provider identified in the PFS, please provide a completed and signed (but undated) Health Care Authorization in the form attached as **Exhibit "A."**

2. Tax Return 4506 and 4506-T IRS Forms

   a) Only if you answered "yes" to question III.H and are asserting a claim for lost wages or a reduction in earning capacity, please provide a completed and signed IRS Form 4506 and 4506-T attached as **Exhibit "B"** for each year identified in your answer to question III.H.

   b) If you answered "no" to question III.H in the PFS and are not asserting a wage loss claim or a reduction in lost earning capacity, you are not required to provide IRS Form 4506 or 4506-T.

3. Authorizations for the Release of Employment Records – If you are asserting a claim for lost wages or a reduction in or loss of earning capacity, please provide a completed and signed (but undated) Employment Authorization in the form attached as **Exhibit "C."**

4. Authorization for Release of Workers' Compensation Records – If you answered "yes" to question II.F in the PFS, please provide a completed and signed (but undated) Authorization for Release of Workers' Compensation Records for each agency or company you submitted your application to in the last 10 years in the form attached as **Exhibit "D."**

5. Authorization for Release of Disability Records – If you answered "Yes" to question II.F in the PFS, please provide a completed and signed (but undated) Authorization for Release for each agency or company you submitted your application to in the last ten (10) years in the form attached as **Exhibit "E."**

6. Insurance Records Authorization – For each company listed in your response to question IV.D in the PFS, please provide a completed and signed (but undated) Authorization for Release of Insurance Records in the form attached as **Exhibit "F."**

7. Authorizations for Release of Records of treatment of behavioral or mental health issues. If you are asserting a claim for emotional distress or mental distress, please provide a completed and signed (but undated) Health Care Authorization in the form attached as Exhibit "**G**."

B. OTHER RELEVANT DOCUMENTS

Documents in your possession, including writings on paper or in electronic form (if you have any of the following materials in your custody or possession, please indicate which documents you have and attach a copy of them to this Plaintiff Fact Sheet:

1. All non-privileged documents you reviewed that assisted you in the preparation of the answers to this Plaintiff Fact Sheet.

   Yes: _____ No: _____

2. A copy of all medical records and/or documents relating to the use of Benicar®, Benicar HCT®, Azor® and/or Tribenzor® from any hospital or health care provider who treated you in the past twenty (20) years 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 Benicar®, Benicar HCT®, Azor® and/or Tribenzor®, including, but not limited to, all imaging studies of any part of your body, and laboratory, pathology, and biopsy reports, that relate in any manner to the diagnosis, treatment, care, or management of your condition and the injuries alleged in your complaint.

   Yes: _____ No: _____

3. All x-rays, CT scans, MRIs or other radiographic images of any part of your body.

   Yes: _____ No: _____

4. All laboratory, pathology and biopsy reports and results of same.

   Yes: _____ No: _____

5. All documents reflecting your use of any prescription drug or medication in the past twenty (20) years, including documents sufficient to identify all antihypertensive medications that you have taken.

   Yes: _____ No: _____

6. All documents constituting, concerning, or relating to product use instructions, product warnings, package inserts, pharmacy handouts, or other materials distributed with or provided to you in connection with your use of Benicar®, Benicar HCT®, Azor® and/or Tribenzor®.

   Yes: _____ No: _____

7. If you have been the claimant or subject of any workers' compensation, social security, or other disability proceeding related to any gastrointestinal issues or your ingestion of any Olmesartan products, all documents relating to such a proceeding.

   Yes: _____ No: _____

8. Copies of advertisements or promotions for Benicar®, Benicar HCT®, Azor® and/or Tribenzor® and articles discussing Benicar®, Benicar HCT®, Azor® and/or Tribenzor®.

   Yes: _____ No: _____

9. Copies of the entire packaging, including the box and label for Benicar®, Benicar HCT®, Azor® and/or Tribenzor® (plaintiffs or their counsel must maintain the originals of the items requested in this subpart).

   Yes: _____ No: _____

10. All documents relating to your purchase of Benicar®, Benicar HCT®, Azor® and/or Tribenzor® including, but not limited to, receipts, prescriptions, prescription records, containers, labels, or records of purchase.

Yes: _____ No: _____

11. All documents known to you and in your possession which mention Benicar®, Benicar HCT®, Azor® and/or Tribenzor®, or any alleged health risks or hazards related to Benicar®, Benicar HCT®, Azor® and/or Tribenzor® in your possession at or before the time of the injury alleged in your Complaint, other than legal documents, documents provided by your attorney, or documents obtained or created for the purpose of seeking legal advice or assistance.

Yes: _____ No: _____

12. All documents in your possession or in the possession of anyone acting on your behalf (not your lawyer) obtained directly or indirectly from any of the Defendants.

Yes: _____ No: _____

13. All documents constituting any communications or correspondence between you and any representative of the defendants.

Yes: _____ No: _____

14. All photographs, drawings, journals, slides, videos, DVDs or any other media, including any "day in the life" videos, photographs, recordings, or other media that you may utilize to demonstrate damages or relating to your alleged injury.
Yes: _____ No: _____

15. Any and all documentation of Plaintiff's use of social media, Internet postings, or other electronic networking website (including, but not limited to, Facebook, MySpace, LinkedIn, Google Plus, Windows Live, YouTube, Twitter, Instagram, Pinterest, blogs, and Internet chat rooms/message boards) relating to Benicar®, Benicar HCT®, Azor® and/or Tribenzor® or any other antihypertensive medications or any of your claims in this lawsuit.

Yes: _____ No: _____

16. Copies of all documents you (and not your lawyer) obtained from any source related to Benicar®, Benicar HCT®, Azor® and/or Tribenzor® or to the alleged effects of using Benicar®, Benicar HCT®, Azor® and/or Tribenzor®.

Yes: _____ No: _____

17. If you claim you have suffered a loss of earnings or earning capacity, your federal tax returns for each of the five (5) years preceding the injury you allege to be caused by Benicar®, Benicar HCT®, Azor® and/or Tribenzor®, and every year thereafter or W-2s for each of the five (5) years preceding the injury you allege to be caused by Benicar®, Benicar HCT®, Azor® and/or Tribenzor®, and every year thereafter.

Yes: _____ No: _____

18. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care providers.

Yes: _____ No: _____

19. Copies of all records of any other expenses allegedly incurred as a result of the injuries alleged in the complaint.

Yes: _____ No: _____

20. All public statements made by or on behalf of you relating to this litigation in your possession.

Yes: _____ No: _____

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

Yes: _____ No: _____

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

Yes: _____ No: _____

23. All documents that describe, refer to, or record any conviction of plaintiff for a felony or crime of dishonesty within the past ten (10) years.

Yes: _____ No: _____

24. All bankruptcy petitions and orders of discharge (if applicable) for all bankruptcy claims made by you or your spouse since the date of your first use of Olmesartan Products.

Yes: _____ No: _____

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, 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 , and that I have supplied/will supply the Authorizations attached to this declaration, in accordance with the terms of this Plaintiff Fact Sheet.

_____ _____

Signature Date