IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
COLUMBUS DIVISION

IN RE MENTOR CORP. OBTAPE TRANSOBTURATOR SLING PRODUCTS LIABILITY LITIGATION	MDL CASE NO. 2004 Ind. Case No. _____

PLAINTIFF FACT SHEET

Please provide the following information for each individual on whose behalf a claim is being made. Whether you are completing this Plaintiff Fact Sheet for yourself or for someone else, please assume that "You" means the person who had the ObTape implanted. In filling out this form please use the following definition: "healthcare provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, and any pharmacy, x-ray department, radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, or other persons or entities involved in the diagnosis, care and/or treatment of you.

In filling out any section or sub-section of this form, please submit additional sheets as necessary to provide complete information. In addition, if you learn that any of your responses are incomplete or incorrect at any time, please supplement your responses to provide that information as soon as you become aware of this information.

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, information and belief.

I. CASE INFORMATION

1. Name of person completing this form: _____

2. Name of person on whose behalf a claim is being made:_____

THE REST OF THIS PLAINTIFF FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO WAS IMPLANTED WITH THE OBTAPE

II. CORE INFORMATION

1. Lot No. for the ObTape (please attach a copy of the stickers shown on the operative report): _____

2. Date of Implantation: _____

3. Name and Address of Implanting Surgeon(s): _____

4. Name and Address of Hospital, Clinic, or Doctor's Office where implantation surgery was performed: _____

5. If the ObTape has been removed, provide the date on which it was removed: _____

6. Name and Address of Surgeon(s) who removed the ObTape: _____

7. Name and Address of Hospital, Clinic, or Doctor's Office where surgery(ies) performed: _____

8. Name of the Manufacturer and Type of the replacement sling, if any: _____

9. Were any potions of the ObTape surgically removed? Yes _____ No _____

   a. If Yes, what is the present location of the removed portions of the ObTape? _____

10. Has any doctor ever told you that there are portions of the ObTape still in your body? Yes _____ No _____

    If Yes, please provide name and address of each such doctor:

11. Has any doctor told you that those portions of the ObTape still in your body need to be removed? Yes _____ No _____

    If Yes, please provide name and address of each such doctor:

III. PERSONAL INFORMATION

1. Name (first, middle name or initial, last): _____

2. Maiden or other names used and dates you used those names:

   _____

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

   _____

4. Identify each address at which you resided for the period from ten years before your ObTape surgery up to the present and the dates you resided at each one.

Address	Dates of Residence

5. Social Security Number: _____

6. Date and place of birth: _____

7. Current marital status: _____

8. If married, please provide the following information:

   Date of marriage: _____
   Name of spouse: _____
   Date and place of birth of spouse _____

9. Name(s) of former spouse(s), date(s) of marriage(s) and dates the marriage(s) were terminated, and the nature of the termination (i.e., death, divorce):

   _____

   _____

10. If you have children, list each child's name and date of birth and whether they were delivered vaginally or by Caesarian.

    _____

    _____

11. Identify all schools you attended, starting with high school:

Name of School	Address	Dates of Attendance	Degree Awarded	Major or Primary Field

12. Are you currently employed? Yes _____ No _____

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

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

If Yes, describe why you left:

_____
_____
_____
_____
_____
_____
_____
_____
_____

13. For the period of time from ten years before you had your ObTape surgery, until the present, please identify all of your employers, with name, address and telephone number, your employment dates, your position there, and your reason for leaving:

Name of Employer	Address and Telephone Number	Dates of Employment and Wage/Salary	Describe Your Position or Duties	Reason for Leaving

14. If you have Medicare, please state your HICN number: _____

15. For the period from ten years before your ObTape surgery to the present, have you been on or applied for workers' compensation, social security, and/or state or federal disability benefits? Yes _____ No _____

If Yes, then as to each application, separately state the following and attach any documents you have which relate to the application and/or award of benefits:

(a) Date (or year) of application: _____

(b) Type of benefits: _____

(c) Nature of claimed injury/disability: _____

(d) Period of disability: _____

(e) Amount awarded: _____

(f) Basis of your claim: _____

(g) Was claim denied? Yes _____ No _____

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

(i) Claim/docket number, if applicable: _____

16. Have you ever filed a lawsuit or made a claim (other than this suit)?

Yes _____ No _____

If Yes, please provide the following information and attach copies of all pleadings, releases or settlement agreements and deposition transcripts you have:

Party You Sued/Made Claim Against	Court in Which Suit Filed/Claim Made	Case/Claim Number	Attorney Who Represented You	Nature of Claim and Injury

17. Have you ever been convicted of, or pled guilty to, a felony or a crime of dishonesty within the past ten years? Yes _____ No _____

If Yes, please state the charge to which you plead guilty or which you were convicted of, as well as the court where the action was pending and the date of such conviction or plea: _____

_____

_____

18. Have you or your spouse ever declared bankruptcy since the date of your initial ObTape surgery? 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:_____

19. Have you or your spouse (if he/she is pursuing a loss of consortium claim) received any money from a third party in exchange for an assignment of any portion of your claim or recovery in this lawsuit, so that the payer or assignee has decision making authority over the terms of any settlement or other resolution of your claim or has lien rights (excluding liens by healthcare providers) against any funds generated by the resolution of your claim? Yes _____ No _____

If Yes, please state:

The name and address of the third party with whom you have entered into such a contract.

_____

_____

_____

IV. HEALTHCARE PROVIDERS

1. Identify each doctor, healthcare provider, hospital, clinic, surgery center, healthcare facility, physical therapy or rehabilitation centers (including but not limited to family/primary care physicians, surgeons, urologists, gynecologists, infectious disease specialists, physical therapists, practitioners of the healing arts) whom you have seen for medical care and treatment for the period ten years before your ObTape surgery to the present.

Name (Specialty)	Address and Telephone Number	Approx Dates/Years of Visits	Reason/Procedure Performed

2. Identify each pharmacy, drugstore or any other facility or supplier (including but not limited to mail order pharmacies) where you ever received any prescription medication for the period ten years before your ObTape surgery to the present.

Name of Pharmacy/Supplier	Address and Telephone Number of Pharmacy/Supplier	Approx Dates/Years You Used Pharmacy/Supplier

V. MEDICAL BACKGROUND

1. Current Height: _____

2. Please state your weight at the following times:

   (a) Current: _____

   (b) Time of implant: _____

   (c) Time of explant/excision surgery (if any): _____

3. Smoking History

   (a) Have you ever smoked cigarettes? Yes _____ No _____

   State amount smoked: _____ packs per day for _____ years, during the years _____ to _____.

4. Other Conditions

   (a) To the best of your knowledge, have you ever experienced or been diagnosed with any of the following conditions from the time beginning ten years before your ObTape surgery to the present? Please select Yes or No for each condition. For each condition for which you answer Yes, please provide the additional information requested in the table following this chart:

Condition Experienced or Diagnosed	Yes	No	Don't Know
1. Abnormal pap smear			
2. Autoimmune disease			
3. Bacterial vaginosis			
4. Cervical cancer			
5. Cystocele			
6. Diabetes			
7. Endometriosis			
8. Gestational diabetes			
9. Hormone deficiency			
10. Hypertension/high blood pressure			
11. Interstitial cystitis			
12. Obesity			
13. Ovarian cancer			
14. Pelvic inflammatory disease			
15. Polycystic ovary disease			

Condition Experienced or Diagnosed	Yes	No	Don't Know
16. Rectocele			
17. Stress urinary incontinence			
18. Thyroid disorder			
19. Toxic shock syndrome			
20. Urethral erosion			
21. Urinary tract infection			
22. Urge incontinence			
23. Uterine cancer			
24. Vaginal erosion			
25. Vaginal infection			
26. Venereal disease			
27. Yeast infection			

(b) For each condition for which you answered Yes in the previous chart, please provide the information requested below:

Condition You Experienced	Approximate Date of Onset	Name, Address and Telephone Number of Treating Physician (if any)	Treatment Received

VI. MEDICATIONS

1. List all of the medications (prescription and over the counter) you currently take.

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

2. To the best of your recollection, are there any prescription medications other than those identified that you have taken on a regular basis for any duration of more than two months for the period ten years before your ObTape surgery to the present?

   Yes _____ No _____

If Yes, please identify the medication(s), the doctor(s) who prescribed it, the approximate dates/years you have taken this medication, and why it was given to you:

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

VII. IMPLANT AND EXCISION/REMOVAL

1. Describe the condition for which the ObTape was implanted: _____

2. Before the implantation of the ObTape, did you receive non-surgical treatment for your stress urinary incontinence? Yes _____ No _____

   (a) State the period during which you received non-surgical treatment:

   (b) State the nature of the non-surgical treatment (*e.g.*, physical therapy, medication, injections): _____

   (c) State the name and address of all doctors or health care providers involved in your non-surgical treatment:

3. Did you see, read or rely upon any documents or other information from Mentor in making your decision to have the ObTape implanted? Yes ___ No ___

   (a) If Yes, identify each document/source of information. _____

   (b) When did you read the document/receive the information? _____

   (c) How did you obtain the document or information? _____

(d) Do you have the document or written information in your possession? If so, please produce a copy of it together with your answers to the Plaintiff Fact Sheet.

Yes _____ No _____ I don't know _____

4. Have you had any communications with any present or former employee of Mentor or concerning ObTape or matters in any way related to this lawsuit?

Yes _____ No _____

If Yes, for each, please state:

Date of Communication	Name of Person with Whom You Communicated	Mode of Communication (In Person, By Phone, By Email, By Mail)	Do you have a writing or recording? (IF SO, PLEASE ATTACH)

If the communication was by phone or in-person, please tell us what was said:

_____
_____
_____
_____
_____
_____

VIII. INJURIES & DAMAGES

1. Are you claiming any physical injuries or illness as a result of the ObTape?

Yes _____ No _____

If Yes, please describe in detail the following:

(a) The physical injuries or illness claimed and when the symptoms began: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(b) Are those injuries or illnesses continuing? Yes _____ No _____

(c) Provide the name and address of each health care provider that you have seen for these problems:

Condition You Experienced	Name, Address and Telephone Number of Health Care Provider (if any)

2. Have you ever been hospitalized as a result of any of these conditions?

Yes _____ No _____

If Yes, please provide the following information:

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

(ii) Approximate date(s) of discharge: _____

(iii)Hospital names(s) and address(es): _____

_____

_____

_____

3. Do you claim any psychological or psychiatric injury (other than garden variety emotional distress) as a consequence of having the ObTape?

Yes _____ No _____

If Yes, please state the following as it pertains to your treatment for any psychiatric and/or psychological condition(s):

Condition	Name and Address of Mental Healthcare Provider (if any)	Approx. Dates/Years of Treatment/Visits (if any)

4. Are you making a claim for lost wages or lost earning capacity?

Yes _____ No _____

(a) If Yes, describe your claim and attach your W-2 forms for the relevant years. Your description should include the total amount of time (and amount of income) which you have lost or will lose from work as a result of any condition which you claim or believe was caused by the ObTape, and an explanation of how those amounts were calculated:

_____

_____

_____

_____

_____

_____

_____

_____

(b) If you claim a loss of earnings, state your earned income from work for the following years:

YEAR	INCOME
2012	$
2011	$
2010	$
2009	$
2008	$
2007	$
2006	$
2005	$
2004	$
2003	$

5. Is your spouse claiming loss of consortium?

Yes _____ No _____

6. Is your spouse claiming physical injury from the ObTape?

Yes _____ No _____

If Yes, please describe in detail the following:

(a) The physical injuries claimed and the approximate date of treatment for each injury, and identify the name and address of each health care provider that your spouse has seen for these problems:

Condition Spouse Experienced	Approximate Date of Treatment	Name, Address and Telephone Number of Health Care Provider (if any)

IX. MEDICAL AND OUT-OF-POCKET EXPENSES

1. State the amount of medical expenses, by provider, which you have incurred, including amounts billed to insurers and other third party payors, which are related to any condition which you claim or believe was caused by the ObTape for which you seek recovery in this action:

Name and Address of Provider	Dates of Treatment	Description of Treatment	Amount of Medical Expenses
			$
			$
			$
			$
			$

For any expenses claimed above, have they been reimbursed by any third party?

Yes _____ No _____

If Yes, identify which expenses, the amount reimbursed and the date reimbursed.

_____
_____
_____
_____
_____

X. FACT WITNESSES

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

Name: _____
Address: _____
Relationship to you: _____

Name: _____
Address: _____
Relationship to you: _____

Name: _____
Address: _____
Relationship to you: _____

XI. DOCUMENT DEMANDS

These document requests are not intended to seek attorney client communications, or attorney work product materials. In addition, these requests do not encompass or seek information about expert witnesses or communications with and/or from experts or proposed trial exhibits or trial materials which may be subject to disclosure at a later date in accordance with subsequent Court Order or rule. Thus, if you have any of the following in your possession which is not protected as set forth above, please provide a copy of it with this Plaintiff Fact Sheet.

REQUEST NO. 1: All medical records (including, but no limited to, all charts, hospital records, consent forms, treating physician records, photographs, videotapes/DVDs, drawings, X-rays, ultrasounds, MRIs, CT scans, radiographs, angiograms, blood tests, laboratory reports, prescriptions, spirometry tests, electrocardiograms, urine tests, blood gases tests, psychometric tests, neuropsychological tests, stress tests, notes, telephone messages) from any physician, hospital, clinic, health care provider, pharmacy, psychiatrist, psychologist, counselor or therapist created since 1990 reflecting, referring or relating to Plaintiff.

REQUEST NO. 2: All medical bills for which plaintiff seeks recovery in this lawsuit, as well as all documents relating to third-party payments of medical bills.

REQUEST NO. 3: All records of any other expenses (including, but not limited to, nursing services, outpatient care, home health care, lost wages, etc.) allegedly incurred as a result of the injuries alleged in the complaint.

REQUEST NO. 4: All photographs and videos of plaintiff's surgery and all photographs and videos of plaintiff which show plaintiff's condition since the date of the original implantation.

REQUEST NO. 5: Any documents including but not limited to literature, warnings or informed consent forms received by you from surgeons, physicians, or other health care professionals who have treated you for any condition related to ObTape.

XII. AUTHORIZATIONS

Complete and sign the Authorization attached as Exhibit A.

XIII. VERIFICATION

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 upon information and belief, that I have supplied all the documents requested in part XI of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and that I have supplied the authorization attached to this declaration.

Date: _____ _____

Signature