

**IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA**

CHARLESTON DIVISION

MDL No. 2327

In Re Ethicon Inc., Pelvic Repair System Products Liability Litigation

In completing this Plaintiff Profile Form, you are under oath and must provide information that is true and correct to the best of your knowledge. The Plaintiff Profile Form shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order.

I. CASE INFORMATION

Caption: _____ **Date:** _____

Docket No.: _____

Plaintiff's attorney and Contact information:

II. PLAINTIFF INFORMATION

Name: _____

Spouse: _____ **Loss of Consortium?** Yes No

Address: _____

Date of birth: _____

Social Security No.: _____

III. DEVICE INFORMATION¹

Date of implant: _____

Reason for Implantation: _____

Brand Name: _____ **Mfg.** _____

¹ Note: In lieu of device information, operating records may be submitted as long as all requested information is legible on the face of the record.

Lot Number: _____

Implanting Surgeon: _____

Medical Facility: _____

Date of implant: _____

Reason for Implantation: _____

Brand Name: _____ Mfg. _____

Implanting Surgeon: _____

Medical Facility: _____

• *Attach medical evidence of product identification.*

IV. REMOVAL/REVISION SURGERY INFORMATION

Date of surgery(s): _____

Type of surgery(s): _____

Explanting surgeon: _____

Medical Facility: _____

Reason for Explant: _____

Date of surgery(s): _____

Type of surgery(s): _____

Explanting surgeon: _____

Medical Facility: _____

Reason for Explant: _____

V. OUTCOME ATTRIBUTED TO DEVICE

<input type="checkbox"/> Pain	<input type="checkbox"/> Fistulae
<input type="checkbox"/> Erosion	<input type="checkbox"/> Recurrence
<input type="checkbox"/> Extrusion	<input type="checkbox"/> Bleeding
<input type="checkbox"/> Infection	<input type="checkbox"/> Dyspareunia
<input type="checkbox"/> Urinary Problems	<input type="checkbox"/> Neuromuscular problems
<input type="checkbox"/> Bowel Problems	<input type="checkbox"/> Vaginal Scarring

<input type="checkbox"/> Organ Perforation	<input type="checkbox"/> Other
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VI. PAST HISTORY

Number of Pregnancies: _____ Number of Live Births: _____

Date of Hysterectomy(ies) and Name of Hospital Where Performed: _____

Prior to the First Implant, Have You Ever Had:

- _____ Lupus
- _____ Diabetes
- _____ Auto Immune Disorder
- _____ Endometriosis
- _____ Pelvic Pain Syndrome or Disorder
- _____ Fibroids
- _____ Adhesive Disease

Are you claiming damages for lost wages: [] Yes [] No

If so, for what time period: _____

Have you ever filed for bankruptcy: [] Yes [] No

If so, when? _____

Do you have a computer: [] Yes [] No

If so, are you a member of Facebook, LinkedIn or other social media websites:

[] Yes [] No

Which ones: _____

VII. LIST OF ALL TREATING PHYSICIANS FOR THE PERIOD OF 10 YEARS PRIOR TO THE FIRST MESH IMPLANT, INCLUDING ALL PRIMARY CARE PHYSICIANS, OB-GYNS, UROLOGISTS, ENDOCRINOLOGISTS, RHEUMATOLOGISTS, PSYCHIATRISTS, PSYCHOLOGISTS, OR ANY OTHER SPECIALISTS

Primary Care Physicians:

Name: _____

Address: _____

Approximate Period of Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

OB-GYNs:

Name: _____

Address: _____

Approximate Period of Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

Urologists:

Name: _____

Address: _____

Approximate Period of Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

Psychiatrists/Psychologists (Answer only if making a claim for emotional/psychological Injury beyond usual pain and suffering):

Name: _____

Address: _____

Approximate Period of Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

Attach additional pages as needed to identify other health care providers you have seen.

AUTHORIZATIONS

Provide ONE (1) SIGNED ORIGINAL copy of each of the records authorization forms attached as Ex. A. These authorization forms will authorize the records vendor selected by the parties to obtain those records identified in the authorizations from the providers identified within this Plaintiff Profile Form.

VERIFICATION

I, _____, declare under penalty of perjury subject to all applicable laws, that I have carefully reviewed the final copy of this Plaintiff Profile Form dated _____ and verified that all of the information provided is true and correct to the best of my knowledge, information and belief.

Signature of Plaintiff