IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

IN RE: ZOLOFT (SERTRALINE HYDROCHLORIDE) PRODUCTS LIABILITY LITIGATION	:	**MDL NO. 2342** **12-MD-2342**
	:	**HON. CYNTHIA M. RUFE**
THIS DOCUMENT RELATES TO: **MDL Case No.:** **Case Name:**	:	

INITIAL PLAINTIFF FACT SHEET

A. CASE INFORMATION - Please state the following for the civil action you filed:

1. Case caption: _____
2. Court in which case was originally filed: _____
3. MDL Case Number: _____
4. Principal Attorney name: _____

   Firm: _____

   Telephone number: _____Fax number: _____

   E-mail address: _____

B. PERSONAL INFORMATION FOR BIRTH PARENTS

1. Mother's Current full name:

   _____ _____ _____
   First Middle Last
2. Mother's other names, including maiden names, nicknames, and aliases, you have used or by which you have been known, and the date(s) of use:

   _____ _____ _____ _____
   First Middle Last Date(s)

   _____ _____ _____ _____
   First Middle Last Date(s)

   _____ _____ _____ _____
   First Middle Last Date(s)
3. Mother's social security number(s): _____ _____
4. Mother's Date of Birth (MM/DD/YYYY): _____
5. Father's Current full name:

   _____ _____ _____
   First Middle Last

6. Father's other names, including nicknames and aliases you have used or by which you have been known, and the date(s) of use:

First	Middle	Last	Date(s)
First	Middle	Last	Date(s)

7. Father's Date of Birth: _____

8. Birth Mother's Residence(s). Identify each address at which you have resided for the period beginning two years prior to the birth of the Minor Plaintiff and continuing to the present. Complete all information. Attach additional pages as necessary.

Address	City	State	Zip	Dates (MM/YY)
				to
				to
				to
				to

9. Other Lawsuits. If the birth parents have ever been a party to an arbitration or a civil lawsuit, other than the present action, related to this injury, please complete:

Case Name, Court & Case Number	Date filed	Nature of case & resolution

C. PERSONAL INFORMATION FOR MINOR PLAINTIFF

1. Name: _____
   First Middle Last
2. Date of birth: _____
3. Gender: ☐ Male ☐ Female
4. Place of birth: _____
   Hospital City State
5. Social security number: _____
6. If the Minor Plaintiff has died, please provide:
   Cause of death:_____ Date of death:_____
   Place of death:_____
   Hospital City State

7. Daycare Facilities or Schools. For each daycare facility, school or similar facility or institution the Minor Plaintiff has attended, please complete:

Name of daycare, school or institution	Address	City	State	Zip	Dates of attendance
					to
					to
					to

D. FAMILY INFORMATION

To your knowledge, have any of the following **biologically-related** relatives of the Minor Plaintiff had a congenital birth defect or abnormality:

Relative	Birth Mother and Father of Relative	Describe Condition
Mother		
Father		
Siblings or half-siblings		
Grandparents		
Aunts and uncles		
First cousins		
Nieces and nephews		

E. ALLEGED INJURIES AND DAMAGES

1. For each injury that you believe the Minor Plaintiff sustained as a result of the Mother Plaintiff's ingestion of Zoloft or sertraline hydrochloride, please provide the following and attach all medical records related to the injuries (you may not rely on your provision of authorizations for records and must either respond fully below or attach all records):

Injury	Date diagnosed (MM/DD/YY)	Diagnosing physician	Address	City	State	Zip Code

2. List each procedure or operation that has been undertaken or scheduled to correct or treat any of the injuries alleged in the immediately preceding section and attach all medical records related to the procedures (you may not rely on your provision of authorizations for records and must either respond fully below or attach all records):

Procedure or operation	Date performed (MM/DD/YY)	Performing physician	Address	City	State	Zip Code

F. HEALTH AND MEDICAL HISTORY FOR MOTHER PLAINTIFF

1. **Zoloft/sertraline hydrochloride – Prescribing Healthcare Providers.** Identify each Healthcare Provider who ever prescribed (or provided samples of) Zoloft or sertraline hydrochloride to the Mother Plaintiff. If you do not know the name of the Healthcare Provider, please identify the Healthcare Facility. Attach additional pages as necessary.

Prescribing Provider or Facility	Address	City	State	Zip	Specialty	Dates of prescription
						to
						to
						to
						to

2. **Zoloft Monograph.** If you are asserting any claim based upon any Zoloft patient education monograph information that you received (e.g., a leaflet provided with your prescription or written information provided by your doctor or nurse), either: (a) provide copies of any such information you received, or (b) describe the information, including number of pages, whether it included your name or your healthcare provider's name, any statements it included that you believe were inaccurate or incomplete, and why you believe Wolters Kluwer Health wrote or published the information.

3. **Healthcare Providers**. Identify each Healthcare Provider (not listed above) with whom the Mother Plaintiff consulted or who examined the Mother Plaintiff for any mental or physical illness, injury, condition, or disability from two years prior to the birth at issue through the birth. If you do not know the name of the Healthcare Provider, please identify the Healthcare Facility. Attach additional pages as necessary.

Healthcare Provider or Facility	Address	City	State	Zip Code	Specialty

4.**Pharmacies.** Provide the following information for all pharmacies at which the Mother Plaintiff filled prescriptions for medications, specifically including but not limited to those pharmacies at which the Mother Plaintiff filled prescriptions for Zoloft or sertraline hydrochloride, from two years prior to the birth of the Minor Plaintiff through one year after the birth. This includes all drug stores, supermarkets, hospital pharmacies, or any other location from which medications were purchased or obtained. Attach additional pages as necessary (alternatively, provide all pharmacy records described).

Name of Pharmacy	Address	City	State	Zip Code	Zoloft supplied?

5. **Medications.** Please provide the following information for any type of non-prescription medication, drug, or dietary supplement, either prescribed, including vitamins, herbal preparations, and prenatal vitamins (collectively, "Medication"), that the Mother Plaintiff took from two years prior to the Minor Plaintiff's birth through the birth. Attach additional pages as necessary.

Name of Medication	Name of Medication

6. **Mental Health Issues.** Please provide the following information for the Mother Plaintiff's mental health issues from two years prior to the birth at issue through the birth. Attach additional pages as necessary.

Mental health issue or condition	Date first diagnosed or treated	Diagnosing and/or treating Healthcare Provider(s)	Issue or condition ongoing?

7. **Pregnancies.** For each and every pregnancy the Mother Plaintiff has ever had, regardless of whether the pregnancy resulted in birth, provide the following. Attach additional pages as necessary.

Live Birth?	Date of birth or loss	Weeks at birth/loss	
Were there any complications in pregnancy or birth? (describe)			
Was assisted reproductive technology used? (describe)			
Was the pregnancy terminated due to medical reasons? If so, describe.			
Were any congenital or chromosomal defects diagnosed or suspected in fetus or child? (describe)			

Live Birth?	Date of birth or loss	Weeks at birth/loss	
Were there any complications in pregnancy or birth? (describe)			
Was assisted reproductive technology used? (describe)			
Was the pregnancy terminated due to medical reasons? If so, describe.			
Were any congenital or chromosomal defects diagnosed or suspected in fetus or child? (describe)			

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Was assisted reproductive technology used? (describe)			
Was the pregnancy terminated due to medical reasons? If so, describe.			
Were any congenital or chromosomal defects diagnosed or suspected in fetus or child? (describe)			

8. **Diabetes –** Was the Mother Plaintiff ever diagnosed with or treated for diabetes?
   Yes ☐ No ☐

   If YES, when (MM/YY): _____

   Who made the diagnosis: _____

   Address:_____

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, and that I have supplied all the documents requested in 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, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in some material respects incomplete or incorrect.

Further, by signing below, I waive notice under the Federal Rules of Civil Procedure, or other applicable law or rule, of subpoenas or other requests for production of medical records directed to Healthcare Providers identified in this Plaintiff Fact Sheet.

_____ _____

Plaintiff's Name (Signature) Date

_____

Plaintiff's Name (Printed)