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QUESTIONNAIRE FOR ZELNORM USERS

Name: _____

Address: _____

E-mail Address: _____

Home Phone: _____ Work Phone: _____

S.S. #: _____ - _____ - _____ Date of Birth: _____ - _____ - _____

Employer: _____ Job Title: _____

Employer Address: _____

Number of Years Employed: _____ Salary: _____

Marital Status: _____ Spouse's Name: _____

Spouse's S.S. #: _____ - _____ - _____ Date of Birth: _____ - _____ - _____

Spouse's Employer: _____ Job Title: _____

Spouse's Business Phone: _____

Children (names & ages): _____

EDUCATION

Last Grade Completed: _____

School: _____

University: _____

Degree: _____

Special Training: _____

Other: _____

INSURANCE

Health Ins. Or Major Medical Carrier: _____

Identification No.: _____

Group #: _____

Other: _____

HOBBIES

Sports you participate in (how frequently): _____

Other recreational activities (how frequently): _____

Membership in organizations or service clubs: _____

MILITARY SERVICE

Branch: _____

Rank: _____

Dates: _____

Duties: _____

Awards: _____

Type of Discharge & Date: _____

PRIOR MARRIAGES

To Whom: _____

When: _____

Where: _____

If Divorced, give date: _____

If Former Spouse is deceased, give date: _____

Have you ever been involved in a lawsuit before? _____

Explain: _____

Date: _____

Attorney (name, address, & phone): _____

Date Diagnosed with Irritable Bowel Syndrome: ___/___/___

Physician Name/Address who diagnosed Irritable Bowel Syndrome:

Describe Medical History for Irritable Bowel Syndrome Prior to Zelnorm use:

Physician Name/Address who prescribed Zelnorm:

What did the physician tell you, if anything, about the risks of Zelnorm:

Date Started Zelnorm: ___/___/___

Dosage: _____

Date Ended Zelnorm: ___/___/___

Name & Address of all pharmacies that a prescription was filled:

Name & Address of all hospitals where you received care related to Zelnorm:

List all other medications you were taking when you were taking Zelnorm:

List any problems you developed while you were taking Zelnorm:

Did your physician monitor you while on Zelnorm: ____ Yes ____ No

If so, how frequently: _____

The results: _____

Name/Address of facility performing tests: _____

When did you first suspect that you had complications as a result of taking Zelnorm:

Did a doctor ever tell you that you were injured as a result of taking Zelnorm?

____ Yes ____ No

If so, when: ____ / ____ / ____

Have you been diagnosed with any of the following heart conditions:

Heart Attack ___ yes ___ no Date of diagnosis ___/___/___

Arrhythmia ___ yes ___ no Date of diagnosis ___/___/___

Atrial Fibrillation ___ yes ___ no Date of diagnosis ___/___/___

Ventriular Fibrillation ___ yes ___ no Date of diagnosis ___/___/___

Unstable Angina ___ yes ___ no Date of diagnosis ___/___/___

Ventricular Tachycardia ___ yes ___ no Date of diagnosis ___/___/___

Irregular Heart Beat ___ yes ___ no Date of diagnosis ___/___/___

Heart Murmur ___ yes ___ no Date of diagnosis ___/___/___

Meningitis ___ yes ___ no Date of diagnosis ___/___/___

Type of Meningitis: _____

Stroke: ___ yes ___ no Date of diagnosis ___/___/___

TIA or other Event ___ yes ___ no Date of diagnosis ___/___/___

Nature of treatment: _____

Current Physician(s) treating for Above Condition(s) (Provide Name & Address):

Have you ever had an electrocardiogram (EKG): ___ yes ___ no

If so, list dates of exam & name & address of facility that performed exam:

___/___/___ _____

___/___/___ _____

Have you ever been instructed to wear a 24-hour halter monitor to evaluate your heart condition? If so, indicate the name and address of the doctor who instructed you to wear the monitor:

What were the results of the test: _____

Have you had any other testing or treatment as a result of taking these medications?

____yes ____ no

If so, describe what kind of tests or treatment and results: _____

FAMILY HISTORY: Mother, Father, Sisters, Brothers; Alive & Well? _____

MAJOR ILLNESSES among family members: _____

Previous Illnesses: _____

Prior Hospitalizations: _____

Past Surgical History: _____

Previous Injuries: _____

Previous Medical Conditions (i/e. Arthritis, etc.) _____

Family Physician (address & phone #): _____

Present Physician (address & phone #): _____

How did you first become aware that you may have injuries that may be the result of drugs or medical malpractice? _____

Identify all doctors, hospitals or other health care providers whom you feel may be responsible for your injury? _____

Identify any member of the health care profession who told you, or suggested to you, your injuries were the result of malpractice or medication: _____

On what date did you first become aware of the fact that your injuries may be the result of malpractice or medication? Explain:

Signature

Name

Date: _____