

# ATTACHMENT 2



**FILED**

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Carol E. Higbee, P.J.Cv.

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ATTORNEYS FOR DEFENDANT MERCK & CO., INC.

In re: VIOXX® Litigation

SUPERIOR COURT OF NEW JERSEY  
LAW DIVISION: ATLANTIC COUNTY

CASE NO.: 619

CIVIL ACTION  
APPLICABLE TO ALL CASES

**ORDER**

This Order applies to all plaintiffs represented by counsel who file personal injury claims directly in, or whose claims were transferred into, Case No. 619 on or after November 9, 2007 ("Post 11.09 Plaintiffs") and who receive notice of this Order. Counsel for Merck shall serve Notice of this Order by registered mail on any counsel who files a claim after November 9, 2007 that is coordinated in Case No. 619.

**I. PRESERVATION NOTICE REQUIREMENT**

- A.** Counsel shall be responsible for ensuring that all records in the possession of the plaintiffs' pharmacies and healthcare providers as described in paragraph (B) below have been preserved, collected and reviewed. Thirty days after receiving notice of this Order, counsel shall notify the individuals or entities listed below in Paragraph B, by registered mail, that they may have records relevant to the putative plaintiff's ("Plaintiff or Plaintiff's") claim ("Claim") in the In Re Vioxx® Litigation ("Litigation") and that any records relating to the Plaintiff must be preserved pursuant to Case Management Order No. \_\_\_ entered by this Court (the "Notice"), pending collection by the Plaintiff.
- B.** The following individuals or entities must be notified pursuant to Paragraph 1 above:
1. All Pharmacies that dispensed any medications to the Plaintiff for the period from January 1, 1995 to the present;
  2. All Physicians, Medical Facilities, other Healthcare Providers and/or others persons ("other Providers") who Plaintiff claims provided any samples of Vioxx to the Plaintiff;
  3. All Physicians, Medical Facilities and/or other Healthcare Providers who prescribed Vioxx for the Plaintiff;
  4. All Physicians and/or other Healthcare Providers who treated Plaintiff for the period from January 1, 1995 to the present; and
  5. If Plaintiff is seeking lost wages, all of his employers for the period from three years prior to the date for which he is seeking lost wages through the last day for which Plaintiff is seeking lost wages.
- C.** A copy of Case Management Order No. \_\_\_ shall be attached to the Notice and all copies of the Notice shall be preserved by Counsel for Plaintiff for so long as the claim remains pending in this Proceeding.
- D.** Within ~~ten (10) days~~ <sup>60</sup> days of filing a claim, Plaintiff shall serve a statement listing the names and addresses of all individuals or entities to which Notices were sent, along with copies of the Notices and a signed certification that the Notices were sent as required by this Order.
- E.** Plaintiffs who fail to fully comply with the requirements of this Order shall be given notice by e-mail or fax from Defendants' Liaison Counsel or his designee and shall be provided thirty (30) additional days to cure such deficiency ("Cure Period"). No other extensions will be granted, except for good cause shown. If Plaintiff fails to cure the deficiency within the Cure Period, Defendant's Liaison Counsel shall file a Motion to Show Cause why the claim should not be dismissed with prejudice. Plaintiff shall thereupon have thirty (30) days to respond to the Notice to Show

Cause. Any failure to respond to the Motion within the required period of time shall lead to the dismissal of the claim with prejudice, except for good cause shown.

- F. Plaintiff may not seek to introduce into evidence at trial any document or information asserting that Vioxx was dispensed by a pharmacy or that Vioxx was provided to the Plaintiff as a sample if a Notice were not sent to the Plaintiff's pharmacy, physician, other healthcare provider and/or Other Provider as required by this Order, except upon leave of court for good cause shown. A Plaintiff who fails to comply with this Order may also be subject to other sanctions or orders.

## II. DISCOVERY REQUIREMENTS

- A. Within forty-five (45) days of filing his or her claim in this Litigation, all Post 11.09 Plaintiffs who claim to have suffered an injury as a result of the use of Vioxx must produce the following information:
1. All pharmacy records regarding the dispensing of drugs to the Plaintiff for the period from January 1, 1995 to the present, along with a signed certification from the respective pharmacies indicating that the production is complete.
  2. All medical records relating to the Plaintiff from all healthcare providers requested in the Amended and Supplemental Plaintiff Profile Form for the period from January 1, 1995 to the present, along with a signed certification from each Healthcare Provider who has records relating to the Plaintiff indicating that all records in the possession, custody or control of the Provider have been produced.
  3. If any death is claimed, a statement to that effect along with a copy of the death certificate and autopsy report, if one was performed,
  4. An Amended Plaintiff Profile Form (attached as Exhibit A), records requested therein, and executed Authorizations for Release of Records pursuant to Case Management Order No. \_\_\_.
  5. Answers to the Interrogatories set out in Exhibit B.
  6. An affidavit signed by the Plaintiff (i) attesting that records have been collected from all pharmacies that dispensed drugs to, or for, the plaintiff; (ii) attesting that all medical records described in paragraph (3) above have been collected; and (iii) attesting that all records collected pursuant to subparagraphs (1), (2) and (3) have been produced pursuant to the Order, along with an index or list identifying the source of the records.
- B. Within thirty (30) days of the filing of a new claim in this Litigation, the Court shall set a status conference at which time the Court shall set a prompt deadline for:

1. A case-specific expert report from a medical expert attesting (i) that the Plaintiff suffered an injury and (ii) that Vioxx caused the injury. The case specific expert report must include (i) an explanation of the bases of the attestation that Vioxx caused the plaintiff to suffer the injury; (ii) an identification of any other causes that were considered in formulating the opinion; (iii) a description of the specific injuries allegedly suffered; (iv) a description of the specific medical findings that support the diagnosis of those injuries; and (v) an identification of all documents relied on by the expert in forming his opinions.
- C. If any of the documents described in subparagraphs A (1), (2) and (3) do not exist, the Plaintiff shall state that fact in his or her affidavit and the reason why they do not exist and provide a certified "No Records Statement" from the pharmacy or healthcare provider..
- D. Plaintiffs who fail to fully comply with the requirements of this Order shall be given notice by e-mail or fax from Defendants' Liaison Counsel or his designee and shall be provided thirty (30) additional days to cure such deficiency ("Cure Period"). No other extensions will be granted, except for good cause shown. If Plaintiff fails to cure the deficiency within the Cure Period, Defendant's Liaison Counsel shall file a Motion to Show Cause why the claim should not be dismissed with prejudice. Plaintiff shall thereupon have thirty (30) days to respond to the Notice to Show Cause. Any failure to respond to the Motion within the required period of time shall lead to the dismissal of the claim with prejudice.

### III. ATTORNEYS FEES FOR POST 11.09 PLAINTIFFS

This Court finds that:

A. The Status of the Litigation:

1. Prior to September 30, 2004, approximately 400 lawsuits had been filed against Merck & Co. by plaintiffs alleging various injuries from the use of Vioxx. In New Jersey, an Order had been entered on May 20, 2003 establishing a coordinated proceeding for Vioxx litigants and, on September 30, 2002, an Order was entered in California for the same purpose.
2. On September 30, 2004, Merck withdrew Vioxx from the market. The withdrawal of Vioxx led to extensive publicity nationwide in newspapers and magazines, on television and radio, and across the Internet. While plaintiffs' counsel had extensively advertised seeking clients to pursue claims against Merck relating to the use of Vioxx before September 30, 2004, that advertising increased markedly throughout the country after the withdrawal. Like the publicity relating to the withdrawal, the advertising apprised the public of possible claims they might have against Merck in connection with the use of Vioxx.
3. By December 31, 2004, three months after the withdrawal of Vioxx, approximately 923 lawsuits were on file, encompassing approximately 3291 plaintiffs.
4. By the first year anniversary of the withdrawal of Vioxx, more than 8,900 Vioxx lawsuits had been filed involving more than 18,500 plaintiffs. As of the date of this Order, there are more than 26,800 active Vioxx cases on file in various courts throughout the country, involving more than 47,500 plaintiffs and an additional 13,000 claims on tolling agreements for a total of more than 60,500 claimants. By any measure, the scale of this litigation is large.
5. Discovery in this litigation has also been extensive. More than 54 million pages of documents and a terabyte of data have been produced by Merck pursuant to various requests from plaintiffs' counsel along with another 86 million pages of data from Merck Profile Forms. More than 1,800 depositions have also been taken in the litigation and depositions have consumed more than 2,000 days and comprise more than 380,000 pages of testimony. Also, more than fifteen trials have been conducted.

B. Pharmaceutical Tort Litigation and Contingent Fees.

1. It is the practice in the United States for lawyers bringing claims on behalf of clients in personal injury actions to be compensated pursuant to contingent fee agreements. That is, the lawyer's fee is contingent on the lawyer's success in the recovery of compensation from another party for his client.

2. In large-scale pharmaceutical tort litigation, it is particularly commonplace for lawyers representing plaintiffs to be compensated through contingent fees.
  3. Large-scale pharmaceutical tort litigation (which can be similar to traditional mass tort litigation in scale) can be, and usually is, extraordinarily expensive, particularly in the early stages. It is well understood that proving cases in mass tort litigation, at least at first, is expensive. Experts of various kinds may be needed and discovery from the defendants may take a long time and much effort.
  4. However, the cost and risk inherent in prosecuting the first series of claims in a large-scale pharmaceutical tort is not the same throughout the litigation.
  5. Because of the extensive publicity and extensive advertising that followed the withdrawal of Vioxx, users of Vioxx (and their lawyers) have had ample notice of the possibility that they may have a claim against Merck in connection with their use of the drug. The uncertainty of the number of potential claims in a litigation of this magnitude makes the management of this proceeding exceedingly difficult both for the parties and the Court.
- C. The Vioxx Litigation is an extremely mature litigation. To date, MDL and state court lawyers have tried 17 cases, taken over 1,800 depositions, more than 50 million pages of documents have been produced plus an enormous volume of electronic data, and substantial Third Party discovery has occurred. Because of this extensive work done by the PSC and certain state court lawyers, the cost of litigation Vioxx claims has been substantially reduced.
- D. Given the extensive amount of discovery and trial preparation that has been undertaken and already achieved -- as well as the work on, and lessons learned from, bellwether trials conducted in this Court and others over the last several years, counsel filing new claims can reasonably expect to expend much less time and resources prosecuting those cases than counsel who have been involved in those proceedings from the beginning, and I encourage counsel to consider such disparity in negotiating attorneys' fees.

DATED: Nov 9, 2007

  
\_\_\_\_\_  
Honorable Carol Higbee  
Judge of the Superior Court

# Exhibit A



In re: **Vioxx® Litigation**

SUPERIOR COURT OF NEW JERSEY  
LAW DIVISION: ATLANTIC COUNTY

Case Code No. 619

Plaintiff: \_\_\_\_\_  
(name)

**AMENDED AND SUPPLEMENTAL PLAINTIFF PROFILE FORM**

This Amended and Supplemental Plaintiff Profile Form ("ASPPF") is to be completed and served pursuant to the requirements of Section II.(A).(4) of the Order governing Post 11.09 Plaintiffs ("Post 11.09 Plaintiffs' Order") dated November 9, 2007 and Section II.(A).(4) of the Order on Cases Pending as of November 9, 2007 ("Pre 11.09 Plaintiffs' Order") dated November 9, 2007.

Other than in Sections I (C) and VIII, those questions using the term "You" should refer to the person who used Vioxx. Please use the Additional Information pages, located at the end of this form, as necessary to fully answer these questions. Sources of Information must be completed by each plaintiff who used Vioxx or their personal representative. Section VIII must be completed by loss of consortium plaintiffs.

If you are completing this questionnaire in a representative capacity, please respond to all questions with respect to the person who used Vioxx, unless the question instructs you otherwise. Those questions using the term "You" refer to the person who used the Vioxx, unless you are instructed otherwise. 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. 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, mental, emotional or psychological care or advice and any pharmacy, counselor, dentist, X-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, therapist, nurse, herbalist, nutritionist, dietician or other persons or entities involved in evaluation, diagnosis, care and/or treatment;

(2) "**document**" means any writing or record or any type, however produced and whatever the medium on which it was produced or reproduced, and includes, without limitation, the original and any non-identical copy (whether different from the original because of handwritten notes or underlying on the copy or otherwise) and all drafts of papers, letters, telegrams, telexes, notes, notations, memoranda of conversations or meeting, calendars, diaries, minutes of meetings, interoffice communications, electronic mail, message slips, notebooks, agreements, reports, articles, books, tables, charts, schedules, memoranda, medical records, X-rays, advertisements, pictures, photographs, films, accounting books or records, billings, credit card records, electrical or magnetic recordings or tapes, or any other writings, recordings, or pictures of any kind of description.

**I. CASE INFORMATION**

A. Name of person completing this form: \_\_\_\_\_

B. Please state the following for the civil action which you filed:

1. Case caption: \_\_\_\_\_

2. Case No.: \_\_\_\_\_

3. Please state the name, address, and telephone number of the principal attorney representing you. If you are not represented by an attorney in this case, please state "none."

Name: \_\_\_\_\_

Firm name: \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

Telephone number: \_\_\_\_\_

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

1. Your name: \_\_\_\_\_

2. Social Security Number: \_\_\_\_\_

3. Any other names used or by which you have been known, including but not limited to maiden name: \_\_\_\_\_

4. Street Address: \_\_\_\_\_

5. City, State and Zip Code: \_\_\_\_\_

6. If you are serving in a representative capacity, state which individual or estate you are representing, and in what capacity you are representing the individual or estate:  
\_\_\_\_\_

7. If you were appointed as a representative by a court, state the:

\_\_\_\_\_  
Court

\_\_\_\_\_  
Date of Appointment

8. Your relationship to deceased or represented person or person claimed to be injured:

\_\_\_\_\_

9. If you represent a decedent's estate based on a decedent's death, state the date of death of the decedent and the address of the place where the decedent died:

\_\_\_\_\_

\_\_\_\_\_

**D. Claim Information:**

1. Identify each bodily injury you claim resulted from your use of Vioxx: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Identify the date(s) that you claim each injury occurred: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Who diagnosed the conditions? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Did you ever suffer the same type of injury(ies) prior to the date(s) set forth in Section I (D) (2)? Yes \_\_\_\_\_ No \_\_\_\_\_

*If "yes," please specify each prior injury, when it occurred and who diagnosed each prior injury at that time:* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Do you claim that your use of Vioxx worsened a condition that you already had or had in the past? Yes \_\_\_\_\_ No \_\_\_\_\_

*If "yes," set forth the injury or condition; whether or not you had already recovered from that injury or condition before you took Vioxx; and the date of recovery, if any:*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

E. Are you claiming damages for any psychological, psychiatric or other mental or emotional problem as a consequence of using Vioxx? Yes \_\_\_\_\_ No \_\_\_\_\_

*If "yes," describe each kind of injury you allege you suffered and when you allegedly suffered it:* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Also if "yes," did you seek treatment for these injuries?

Yes \_\_\_\_\_ No \_\_\_\_\_

If "yes," provide:

1. Name and address of each person who treated you:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address (if not otherwise provided)

2. Condition(s) for which treated: \_\_\_\_\_

3. When treated: From: \_\_\_\_\_ To: \_\_\_\_\_

4. Medications prescribed for each such condition: \_\_\_\_\_

Also if "yes," state whether you have experienced or been treated for any psychological, psychiatric or other mental or emotional problem prior to the physical injury you claim from Vioxx, including but not limited to panic attacks, anxiety, post traumatic stress disorder, depression, thoughts of hurting yourself or other people, schizophrenia, bipolar disorder, personality disorders (e.g., obsessive compulsive, paranoid, borderline, histrionic, other), generalized anxiety disorder, social phobia/anxiety disorder, post-traumatic stress disorder, depression, mania, poor sleep, poor concentration, suicidal thoughts/attempts, and drug abuse. Yes \_\_\_\_\_ No \_\_\_\_\_

If "yes," state:

5. Name and address of each person who treated you:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address (if not otherwise provided)

6. Condition(s) for which treated: \_\_\_\_\_

7. When treated: From: \_\_\_\_\_ To: \_\_\_\_\_

8. Medications prescribed for each such condition: \_\_\_\_\_

**II. VIOXX® PRESCRIPTION INFORMATION**

A. Who prescribed Vioxx for you? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. On which dates did you begin to take, and stop taking, Vioxx?  
\_\_\_\_\_  
\_\_\_\_\_

C. For what condition were you prescribed Vioxx?  
\_\_\_\_\_  
\_\_\_\_\_

D. Did you receive a prescription for Vioxx? Yes \_\_\_\_ No \_\_\_\_

*If "yes," set forth the name(s) and address(es) of each pharmacy where you filled each Vioxx prescription:* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1. Did you renew your prescription for Vioxx? Yes \_\_\_\_ No \_\_\_\_  
*If "yes," how many times?* \_\_\_\_\_

E. Did you receive any samples of Vioxx? Yes \_\_\_\_ No \_\_\_\_

*If "yes," for each provider, provide the following:*

1. Identify the full name and address of person who provided you a sample of Vioxx:  
\_\_\_\_\_  
\_\_\_\_\_

2. Identify how many tablets of each dosage were provided: \_\_\_\_\_

3. Identify each date samples of each dosage were provided: \_\_\_\_\_  
\_\_\_\_\_

F. Which form of Vioxx did you take (check all that apply)?

- \_\_\_\_\_ 12.5 mg Tablet (cream, round, MRK 74)
- \_\_\_\_\_ 12.5 mg Oral Suspension
- \_\_\_\_\_ 25 mg Tablet (round, yellow, MRK 110)
- \_\_\_\_\_ 25 mg Oral Suspension
- \_\_\_\_\_ 50 mg Tablet (round, orange, MRK 114)

G. How many times per day did you take Vioxx?

\_\_\_\_\_

H. Have you reviewed any written, televised or internet-based advertising or labeling materials regarding Vioxx? Yes \_\_\_\_ No \_\_\_\_

*If "yes," state which written, televised or internet-based advertising or labeling materials you reviewed regarding Vioxx and when you reviewed such materials.* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I. Have you had discussions with any doctor about whether your claimed injury(ies) set forth in Section I (D), above, is related to the use of Vioxx? Yes \_\_\_\_ No \_\_\_\_

*If "yes," provide the following:*

1. Identify the doctor(s) with whom you had such discussions.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address (if not otherwise provided) *(If discussed with more than one doctor, please provide details in the Additional Information page located at the end of this form.)*

J. State whether you requested that any doctor or clinic provide you with Vioxx or a prescription for Vioxx. Yes \_\_\_\_ No \_\_\_\_

K. Were you given any written instructions or warnings regarding the use of Vioxx? Yes \_\_\_\_ No \_\_\_\_

*If "yes," state:*

1. When the written instructions or warnings were given:

\_\_\_\_\_  
\_\_\_\_\_

2. A description of the written warnings or instructions (e.g., package insert, patient product information, pharmacy handout, etc.): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

3. Identify each person or entity from whom you received the warnings or instructions:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

4. Approximate date you received the written instructions or warnings: \_\_\_\_\_

5. Summary of instructions/warnings received: \_\_\_\_\_

L. What other medications (including aspirin), if any, were you taking at the same time you were taking Vioxx?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

M. What other medications (including, but not limited to, aspirin, ibuprofen, naproxen, and Celebrex) have you taken for osteoarthritis, rheumatoid arthritis, or pain relief, and when did you take them? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

1. Do you believe you ever experienced gastrointestinal problems or other adverse side effects from any or all of these other medications? *If "yes,"* list the type of adverse side effect, the medication you were taking and the date(s) on which you experienced the adverse side effect. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

2. Did you believe you experienced any of the adverse side effects listed in your answer to the preceding question while taking Vioxx? *If "yes,"* set forth which adverse side effect you experienced, when, what treatment you received for the adverse side effect, and who prescribed that treatment. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

N. On what date, and in what city and state, did you first experience any symptoms you believe are related to the injury(ies) alleged in Section I (D) and what were those symptoms? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

O. Were there any witnesses to the symptoms identified in Section I (D)? *If "yes,"* state their names, addresses, phone numbers and relationships to you. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

P. When did you first contact a doctor or healthcare professional concerning the injury you allege in Section I (D) and whom did you contact? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Q. If you were taken to a doctor or health care facility for the injury(ies) alleged in Section I (D), state the name and address of the persons, police department, fire department, emergency medical workers, or ambulance company that took you to the doctor or health care facility. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**III. PERSONAL INFORMATION OF THE PERSON WHO USED VIOXX®**

A. Last name: \_\_\_\_\_

First name: \_\_\_\_\_

Middle name or initial: \_\_\_\_\_

B. Any other names used of by which you have been known, including but not limited to maiden name: \_\_\_\_\_

\_\_\_\_\_

C. Social Security Number: \_\_\_\_\_

D. Driver's license number: \_\_\_\_\_ State issuing your license: \_\_\_\_\_

E. Date and place of birth: \_\_\_\_\_

F. Sex: Male \_\_\_ Female \_\_\_

G. Current street address: \_\_\_\_\_

\_\_\_\_\_



- H. Identify each other address at which you have resided during the last ten (10) years, and list when you started and stopped living at each one (if you have not resided at another address in the last ten (10) years please state "none."):

[Redacted]		

- I. Identify each high school, college, university or other educational institution (except grade school) you have attended, the dates of attendance, courses of study pursued, and diplomas or degrees awarded:

[Redacted]			

J. Employment Information.

1. Current employer (if not currently employed, last employer):

Name of employer: \_\_\_\_\_

Address: \_\_\_\_\_

Dates of employment: From: \_\_\_\_\_ To: \_\_\_\_\_

Occupation/Job duties: \_\_\_\_\_

2. List the following for each employer you have had in the last ten (10) years (not including any employer listed in Section III (J) (1) above):

Name of employer: \_\_\_\_\_

Address: \_\_\_\_\_

Dates of employment: From: \_\_\_\_\_ To: \_\_\_\_\_

Occupation/Job duties: \_\_\_\_\_

Name of employer: \_\_\_\_\_

Address: \_\_\_\_\_

Dates of employment: From: \_\_\_\_\_ To: \_\_\_\_\_

Occupation/Job duties: \_\_\_\_\_

Name of employer: \_\_\_\_\_

Address: \_\_\_\_\_

Dates of employment: From: \_\_\_\_\_ To: \_\_\_\_\_

Occupation/Job duties: \_\_\_\_\_

Name of employer: \_\_\_\_\_

Address: \_\_\_\_\_

Dates of employment: From: \_\_\_\_\_ To: \_\_\_\_\_

Occupation/Job duties: \_\_\_\_\_

**K. Military Service Information**

1. Have you ever served in any branch of the U.S. Military?

Yes \_\_\_\_ No \_\_\_\_

*If "yes," please state:*

a. What branch and the dates of service: \_\_\_\_\_

- b. Were you discharged for any reason relating to your physical, psychiatric or emotional condition?

Yes \_\_\_\_ No \_\_\_\_

If "yes," state what that condition was: \_\_\_\_\_  
\_\_\_\_\_

2. Have you ever been rejected from military service for any reason relating to your health or physical condition?  
Yes \_\_\_\_ No \_\_\_\_

If "yes," state what that condition was: \_\_\_\_\_  
\_\_\_\_\_

3. Have you ever served in the military overseas?  
Yes \_\_\_\_ No \_\_\_\_

If "yes," state location and dates: \_\_\_\_\_  
\_\_\_\_\_

L. Insurance/Claim Information

1. Have you ever filed a worker's compensation claim? Yes \_\_\_\_ No \_\_\_\_

If "yes," please state:

a. Year claim was filed: \_\_\_\_\_

b. Court/State where claim was filed: \_\_\_\_\_

c. Claim/docket number, if applicable: \_\_\_\_\_

d. Nature of disability: \_\_\_\_\_

e. Period of disability: \_\_\_\_\_

f. Benefits received, if any: \_\_\_\_\_

g. Identify the full name and address of the entity most likely to have records concerning your claim: \_\_\_\_\_  
\_\_\_\_\_

*(If necessary, to describe more than one claim, please provide details in the Additional Information page located at the end of this form.)*

2. Have you ever filed a social security disability claim (SSI or SSD)?  
Yes \_\_\_\_ No \_\_\_\_

If "yes," please state:

a. Year claim was filed: \_\_\_\_\_

b. Where claim was filed: \_\_\_\_\_

- c. Nature of disability: \_\_\_\_\_
- d. Period of disability: \_\_\_\_\_
- e. Benefits received, if any: \_\_\_\_\_
- f. Identify the full name and address of the entity most likely to have records concerning your claim: \_\_\_\_\_

*(If necessary, to describe more than one claim, please provide details in the Additional Information page located at the end of this form.)*

3. Have you ever been denied life insurance or medical insurance for reasons relating to your medical or physical condition? Yes \_\_\_ No \_\_\_

*If "yes," state when, the name of the company and the company's stated reason for denial:* \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

4. *(Answer this question if you are claiming damages for mental or emotional distress.)* Have you ever been denied life insurance or medical insurance for reasons relating to your mental or emotional condition? Yes \_\_\_ No \_\_\_

*If "yes," state when, the name of the company and the company's stated reason for denial:* \_\_\_\_\_  
 \_\_\_\_\_

5. Has any insurance or other company provided medical coverage to you (either directly or through a group including any employer of yours) or paid medical bills on your behalf at any time, beginning ten (10) years before your alleged injury through the present? Yes \_\_\_ No \_\_\_

*If "yes," then as to each company, separately state:*

Name of the company: \_\_\_\_\_  
 Address of the company: \_\_\_\_\_  
 The account/policy number or designation: \_\_\_\_\_  
 Dates of coverage: \_\_\_\_\_  
 When claim was made: \_\_\_\_\_

6. Have you ever been out of work for more than thirty (30) days for reasons related to your health? Yes \_\_\_ No \_\_\_

If "yes," identify the date you were out of work and the reason(s).

When: From: \_\_\_\_\_ To: \_\_\_\_\_

Reason: \_\_\_\_\_

7. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury? Yes \_\_\_\_ No \_\_\_\_

If "yes," please provide the following:

When the lawsuit or claim was made: \_\_\_\_\_

Court in which such action was filed: \_\_\_\_\_

Case caption: \_\_\_\_\_

Case name: \_\_\_\_\_

Civil action/Docket No.: \_\_\_\_\_

Name(s) of adverse parties: \_\_\_\_\_

Brief description of claims asserted: \_\_\_\_\_

- M. Have you ever been convicted or plead guilty of a crime? Yes \_\_\_\_ No \_\_\_\_

If "yes," identify where, when, and the crime: \_\_\_\_\_

#### IV. FAMILY INFORMATION

- A. List for each marriage the name of your spouse; spouse's date of birth (for your current spouse only); spouse's occupation; date of marriage; date the marriage ended, if applicable; and how the marriage ended (i.e. divorce, annulment, death):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- B. Has your spouse filed a loss of consortium claim in this action? Yes \_\_\_\_ No \_\_\_\_

- C. Has any parent, grandparent, child, or sibling ever been diagnosed with a problem or condition relating to the same organ or organ system identified in your answer to Section I(D)? Yes \_\_\_\_ No \_\_\_\_

If "yes," identify each such person below and provide the information requested.

1. Name: \_\_\_\_\_

Current age (or age at death): \_\_\_\_\_

Type of problem or condition: \_\_\_\_\_

Age at problem or condition: \_\_\_\_\_

If applicable, cause of death: \_\_\_\_\_

2. Name: \_\_\_\_\_

Current age (or age at death): \_\_\_\_\_

Type of problem or condition: \_\_\_\_\_

Age at problem or condition: \_\_\_\_\_

If applicable, cause of death: \_\_\_\_\_

3. Name: \_\_\_\_\_

Current age (or age at death): \_\_\_\_\_

Type of problem or condition: \_\_\_\_\_

Age at problem or condition: \_\_\_\_\_

If applicable, cause of death: \_\_\_\_\_

D. Provide the full name, address and age of each of your children. If you had no children, state "none." \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

E. If you are claiming the wrongful death of a family member, list any and all heirs of the decedent who have standing to assert a wrongful death claim. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

F. If you are bringing a survivor cause of action, state whether you have been appointed as the decedent's personal representative authorized to prosecute the decedent's claims, and when and by whom you were so appointed: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

V. **CURRENT MEDICAL CONDITION**

A. Do you currently suffer from any physical injuries, illnesses or disabilities other than those you alleged are the result of your use of Vioxx in Section I (D)?

Yes \_\_\_\_ No \_\_\_\_

*If "yes," please state the following for each injury, illness or disability:*

1. Identify the injury, illness, or disability, their symptoms and date of onset:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. By whom first diagnosed:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date of diagnosis

VI. **MEDICAL BACKGROUND**

A. Height: \_\_\_\_\_

B. Current Weight: \_\_\_\_\_

C. Weight at the time of the injury, illness or disability described in Section I (D): \_\_\_\_\_

D. Prescription Medicines

1. To the best of your knowledge, state whether you used any of the following from ten (10) years prior to the date of the injury you allege in Section I (D) through the present, check all medications you have used, state the first and last dates you took the medication, and identify the doctor that prescribed the medication.

Medication	Date First Taken	Date Last Taken	Prescribing Doctor	Reason for Prescription
<b>Angiotension Converting Enzyme ("ACE") Inhibitors:</b> Altace: _____ Aceon: _____ Accupril: _____ Monopril: _____ Lotensin: _____ Capoten: _____ Vasotec: _____ Prinivil: _____ Zestril: _____ Univasc: _____ Mavik: _____ Other: _____				High blood pressure: _____ Heart disease: _____ Cardiomyopathy: _____ Previous heart attack: _____ Enlarged heart: _____ Kidney problems: _____ Diabetes: _____ Other: _____
<b>Angiotension II Receptor Antagonists ("ARBs"):</b> Cozaar: _____ Diovan: _____ Avapro: _____ Micardis: _____ Atacard: _____ Other: _____				High blood pressure: _____ Heart disease: _____ Cardiomyopathy: _____ Previous heart attack: _____ Enlarged heart: _____ Kidney problems: _____ Diabetes: _____ Other: _____
<b>Beta Blockers:</b> Inderal: _____ Lopresser: _____ Toprol: _____ Sectral: _____ Corgard: _____ Coreg: _____ Tenormin: _____ Timoptic: _____				High blood pressure: _____ Heart problems: _____ Previous heart attack: _____ Recurrent chest pain: _____ Migraine headaches: _____ Eye problems: _____ Panic disorders: _____ Social phobias: _____ Other: _____



Medication	Date First Taken	Date Last Taken	Prescribing Doctor	Reason for Prescription
Betoptic: _____ Brevibloc: _____ Betapace: _____ Viskin: _____ <b>Other:</b> _____				
<b>Calcium Channel Blockers:</b> Norvasc: _____ Procardia: _____ Calan: _____ Cardizem: _____ Plendil: _____ Cardene: _____ Sular: _____ <b>Other:</b> _____				Recurrent chest pain: _____ Heart problems: _____ Raynaud's phenomenon: _____ Migraine headaches: _____ Esophageal (throat) spasm: _____ <b>Other:</b> _____
<b>Alpha Blockers:</b> Cardura: _____ Minipress: _____ Hytrin: _____ <b>Other:</b> _____				High blood pressure: _____ Benign prostatic hypertrophy (BPH): _____ Heart problems: _____ <b>Other:</b> _____
<b>Diuretics:</b> Hydrodiuril: _____ Hygroton: _____ Microx: _____ Lozol: _____ Lasix (furosemide): _____ Demadex: _____ Dyazide: _____ Aldactazide: _____ Moduretic: _____ <b>Other:</b> _____				High blood pressure: _____ Edema in legs (fluid): _____ Heart problems: _____ <b>Other:</b> _____

	Date First Taken	Date Last Taken	Prescribing Doctor	Reason for Prescription
Central Alpha Agonists: Catapres: _____ Tenex: _____ Aldomet: _____ Wytensin: _____ <b>Other:</b>				High blood pressure: _____ <b>Other:</b>
Other (please list): (can include combination pills, or any other pill thought to be prescribed for high blood pressure):				
Heart Medications: (other than ACE Inhibitors, ARBs, or high blood pressure medications already listed above) Digoxin (lanoxin): _____ Amrinone: _____ Primacor: _____ <b>Other:</b>				
Anticoagulants: Coumadin (warfarin): _____ Heparin or Low Molecular Weight Heparin: _____ <b>Other:</b>				Blood clot (DVT): _____ Atrial fibrillation: _____ Previous heart attack: _____ Prolonged hospitalization: _____ Suspected or proven pulmonary Embolism (PE): _____ Heart valve problems: _____ <b>Other:</b>

Medication	Date First Taken	Date Last Taken	Prescribing Doctor	Reason for Prescription
Aspirin: 81mg: _____ 325mg: _____ Number of times taken each day _____				Prevention for heart attack: _____ Prevention for stroke and/or transient ischemic attack (TIA): _____ Rheumatoid arthritis: _____ Other pain syndromes: _____ Rheumatic fever: _____ Osteoarthritis: _____ Previous heart or other surgery: _____ <b>Other:</b>
Anti-Platelet Medications: (other than aspirin) Plavix: _____ Apo-Dipyridamole: _____ Ticlid: _____ <b>Other:</b>				Heart surgery: _____ Heart attack: _____ Catherization: _____ Stenting: _____ Chest pain at rest: _____ <b>Other:</b>
Cholesterol Lowering Drugs: Lipitor: _____ Zocor: _____ Pravachol: _____ Lescol: _____ Colestid: _____ Niacin: _____ Lopid: _____ <b>Other:</b>				
Pain Medications: Advil: _____ Motrin: _____ Naproxen (can be sold as "Naprosyn"): _____ Aleve: _____ Tylenol (acetaminophen) Actron: _____ Indocin (indomethacin): _____ Migraine medications (e.g., Imitrex): _____ <b>Other:</b>				

Medication	Date Prescribed	Date Last Taken	Prescribing Doctor	Reason for Prescription
<b>Hormone Replacement Therapy:</b> Prempro: _____ Premarin: _____ <b>Other:</b>				
Rifampin: _____				
Theophylline: _____				
Methotrexate: _____				
<b>Diet Drugs or Diet Supplements:</b> Phen-Fen: _____ <b>Other:</b>				
<b>Herbal Remedies or Supplements:</b> Kava: _____ Ginseng: _____ Ginko Biloba: _____ St. John's Wort: _____ Sal Palmetto: _____ <b>Other:</b>				

**Psychiatric Medications** (Only answer these questions if you are claiming damages for mental or emotional distress. If you are not claiming such damages, please go the next question below.)

Medication	Date First Taken	Date Last Taken	Prescribing Doctor	Reason for Prescription
<b>Antidepressants:</b> <b>Tricyclic Anti-Depressants (TCAs):</b> Amitril: _____ Asendin: _____ Anafranil: _____ Adapin: _____ Ludiomil: _____ Vivactil: _____ Surmontil: _____ Elavil: _____ Endep: _____ Norpramin: _____ Pertofrane: _____ Imipramine: _____ Janimine: _____ Tofranil: _____ Aventyl: _____ Pamelor: _____ <b>Other:</b>				Depression: _____ Chronic fatigue syndrome: _____ Bipolar disorder: _____ Generalized anxiety disorder: _____ Panic disorder: _____ Poor concentration: _____ Suicidal thoughts or attempts: _____ Alcohol or drug abuse: _____ Personality disorders: _____ Schizophrenia: _____ Eating disorders: _____ <b>Other:</b>
<b>Selective Serotonin Reuptake Inhibitors (SSRIs):</b> Prozac: _____ Paxil: _____ Zoloft: _____ Celexa: _____ Luvox: _____ <b>Other:</b>				
<b>Monamine Oxidase Inhibitors (MAOIs):</b> Nardil: _____ Parnate: _____ <b>Other:</b>				

	Date Prescribed	Physician	Prescribing Doctor	Reason for Prescription
<b>Anti-Anxiety Medications:</b> <b>Benzodiazepines:</b> Xanax: _____ Librium: _____ Klonopin: _____ Tranxene: _____ Valium: _____ Dalmane: _____ Paxipam: _____ Ativan: _____ Serex: _____ Centrax: _____ <b>Other:</b>				Depression: _____ Chronic fatigue syndrome: _____ Bipolar disorder: _____ Generalized anxiety disorder: _____ Panic disorder: _____ Poor concentration: _____ Suicidal thoughts or attempts: _____ Personality disorders: _____ Alcohol or drug abuse: _____ Schizophrenia: _____ Eating disorders: _____ <b>Other:</b>
<b>Anti-Psychotic Medications:</b> Haldol: _____ Risperdal: _____ Zyprexa: _____ Clozaril: _____ Leponex: _____ Geodon: _____ <b>Other:</b>				Schizophrenia: _____ <b>Other:</b>
<b>Anti-Convulsant Medications:</b> Tegretol: _____ Depakote: _____ <b>Other:</b>				Schizophrenia: _____ Seizure disorder: _____ <b>Other:</b>
Lithium: _____				Bipolar disorder: _____ <b>Other:</b>

2. List each any other prescription medicine not identified in Section VI (D) (1) you have taken regularly in the last ten (10) years, identifying the medication and the condition for which it was prescribed.

---

Medication

---

Condition for which prescribed

---

Medication

---

Condition for which prescribed

---

Medication

---

Condition for which prescribed

---

Medication

---

Condition for which prescribed

- E. Smoking/Tobacco Use History: *(Check the answer and fill in the blanks applicable to your history of smoking and/or tobacco use.)*

\_\_\_ Current smoker of cigarettes \_\_\_; cigars \_\_\_; pipe tobacco \_\_\_; or user of chewing tobacco/snuff \_\_\_.

1. Amount smoked or used: on average \_\_\_ per day for \_\_\_ years.

\_\_\_ Past smoker of cigarettes \_\_\_; cigars \_\_\_; pipe tobacco \_\_\_; or user of chewing tobacco/snuff \_\_\_.

2. Date on which smoking/tobacco use ceased: \_\_\_\_\_

3. Amount smoked or used on average \_\_\_ per day for \_\_\_ years.

\_\_\_ Never smoked cigarettes, cigars, pipe tobacco, or used chewing tobacco/snuff.

- F. Drinking History:

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

Yes \_\_\_ No \_\_\_

*If "no," go Section G below.*

*If "yes,"* check the following box which represents your greatest alcohol consumption over an extended (6 months or greater) period within the last 10 years:

- 1-5 drinks per week
- 6-10 drinks per week
- 11-14 drinks per week
- 15 or more drinks per week
- Other (describe) \_\_\_\_\_

Check the following box which represents your weekly alcohol consumption for the month prior to the time that you sustained the injuries alleged in the complaint:

- 1-5 drinks per week
- 6-10 drinks per week
- 11-14 drinks per week
- 15 or more drinks per week
- Other (describe) \_\_\_\_\_

**G. Caffeine History:**

1. Do you now or have you in the past consumed caffeinated beverages (coffee, tea, sodas, etc.)?  
Yes  No

*If "yes,"* check the following box which represents your greatest caffeine consumption over an extended (6 months or greater) period within the last 10 years:

- 1-5 drinks per week
- 6-10 drinks per week
- 11-14 drinks per week
- 15 or more drinks per week
- Other (describe) \_\_\_\_\_

Check the following box which represents your weekly caffeine consumption for the month prior to the time that you sustained the injuries alleged in the complaint:

- 1-5 drinks per week
- 6-10 drinks per week
- 11-14 drinks per week
- 15 or more drinks per week
- Other (describe) \_\_\_\_\_



H. Illicit Drugs:

1. Have you ever used (even one time) any illicit drugs of any kind within one (1) year before, or any time after, you first experienced any alleged Vioxx-related injury? Yes \_\_\_\_\_ No \_\_\_\_\_

*If "yes," identify each substance and state when you first and last used it.*

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- I. To the best of your knowledge, have you or your parents, grandparents, children or siblings ever experienced, or been told by a doctor or other healthcare professional, that you/they have, may have or had any of the following (check all that apply)?

- Abdominal aortic aneurysm (AAA disease)
- Alcoholism (as to you only, if applicable)
- Allergic reaction to medication
- Amputations (as to you only, if applicable)
- Aneurysm
- Atherosclerosis (blocked or narrow arteries)
- Atrial fibrillation
- Bipolar Disorder (as to you only, if applicable)
- Bleeding/clotting disorders (hemophilia, Von Willibrands disease, scurvy, other)
- Blood in stool or dark/black stools
- Cancer (lung, colon, liver, breast, other)
- Carotid stenosis (neck arteries)
- Chest pain/angina (at rest or with exertion)
- Chronic Fatigue Syndrome
- Chronic obstructive pulmonary disease/COPD
- Congenital heart disease
- Congestive heart failure
- Cor pulmonale
- Coronary heart disease
- Deep vein thrombosis/DVT/blood clot in lower legs
- Dermatomyositis
- Diabetes
- Eating disorders (anorexia, bulimia) (as to you only, if applicable)
- Endocarditis
- Esophagus problems (strictures, achalasia, Barrett's esophagus, difficulty swallowing, other)
- Eye hemorrhages
- Fibromyalgia
- Glaucoma
- Gout
- Heart attack/MI/myocardial infarction
- Heart murmur

- \_\_\_\_\_ Heart valve problems (pulmonary hypertension, mitral valve prolapse, aortic/mitral valve regurgitation, aortic/mitral stenosis, bicuspid aortic valve, other)
- \_\_\_\_\_ Heartburn/ reflux/ esophageal reflux disease/ GERD
- \_\_\_\_\_ Hernia (strangulated or incarcerated)
- \_\_\_\_\_ Herpes (as to you only, if applicable)
- \_\_\_\_\_ High blood pressure/hypertension
- \_\_\_\_\_ High total cholesterol, high LDLs (bad cholesterol), or low HDLs (good cholesterol)
- \_\_\_\_\_ High triglycerides
- \_\_\_\_\_ HIV/AIDS (as to you only, if applicable)
- \_\_\_\_\_ Hodgkins disease/ non-Hodgkin's lymphoma
- \_\_\_\_\_ Hypoxia (low oxygen saturation)
- \_\_\_\_\_ Intestinal obstruction (not including constipation)
- \_\_\_\_\_ Irregular heart rhythm (palpitations, tachycardia, bradycardia, atrial fibrillation, skipped beats, other)
- \_\_\_\_\_ Kidney disease
- \_\_\_\_\_ Leukemia
- \_\_\_\_\_ Liver disease (hepatitis B/C, cirrhosis, cysts, other)
- \_\_\_\_\_ Lupus
- \_\_\_\_\_ Obesity (as to you only, if applicable)
- \_\_\_\_\_ Osteoarthritis
- \_\_\_\_\_ Pancreatitis
- \_\_\_\_\_ Panic Disorder
- \_\_\_\_\_ Peptic ulcer disease
- \_\_\_\_\_ Peripheral vascular disease
- \_\_\_\_\_ Pulmonary embolism/blood clot in the lung
- \_\_\_\_\_ Rheumatic fever (as to you only, if applicable)
- \_\_\_\_\_ Rheumatoid arthritis
- \_\_\_\_\_ Seizure disorder
- \_\_\_\_\_ Shortness of breath not associated with vigorous exercise
- \_\_\_\_\_ Sickle cell anemia/ sickle cell trait
- \_\_\_\_\_ Silent MI
- \_\_\_\_\_ Sleep apnea
- \_\_\_\_\_ Stomach problems (ulcers, perforations, bleeding)
- \_\_\_\_\_ Stroke
- \_\_\_\_\_ Swelling/edema/fluid in legs ankles (other than in pregnancy)
- \_\_\_\_\_ Syphilis (as to you only, if applicable)
- \_\_\_\_\_ Thyroid disorder and/or goiter
- \_\_\_\_\_ Transient ischemic attack/TIA
- \_\_\_\_\_ Tuberculosis

J. ***If you responded "yes" to any of the above***, please identify/state the condition, the individual affected, the date of onset (as to you only, if applicable), any medication prescribed to treat the condition (as to you only if applicable), and the name of the physician or other person who made the diagnosis or informed the individual of the condition and their address if not provided in the accompanying list (as to you only, if applicable).

1. Condition: \_\_\_\_\_

Patient name: \_\_\_\_\_

Onset date and medication: \_\_\_\_\_

Name and address of physician or other person: \_\_\_\_\_

\_\_\_\_\_

2. Condition: \_\_\_\_\_

Patient name: \_\_\_\_\_

Onset date and medication: \_\_\_\_\_

Name and address of physician or other person: \_\_\_\_\_

\_\_\_\_\_

3. Condition: \_\_\_\_\_

Patient name: \_\_\_\_\_

Onset date and medication: \_\_\_\_\_

Name and address of physician or other person: \_\_\_\_\_

\_\_\_\_\_

4. Condition: \_\_\_\_\_

Patient name: \_\_\_\_\_

Onset date and medication: \_\_\_\_\_

Name and address of physician or other person: \_\_\_\_\_

\_\_\_\_\_

5. Condition: \_\_\_\_\_

Patient name: \_\_\_\_\_

Onset date and medication: \_\_\_\_\_

Name and address of physician or other person: \_\_\_\_\_

\_\_\_\_\_

6. Condition: \_\_\_\_\_

Patient name: \_\_\_\_\_

Onset date and medication: \_\_\_\_\_

Name and address of physician or other person: \_\_\_\_\_

\_\_\_\_\_

K. Please indicate whether you have ever received any of the following treatments or diagnostic procedures:

1. Surgeries (other than abortion), including but not limited to the following, and specify for what condition the surgery was performed: open heart or bypass surgery, pacemaker implantation, vascular surgery, IVC filter placement, carotid (neck artery) surgery, lung resection, or intestinal surgery.

2. Treatments/interventions for heart attack, angina (chest pain), or lung ailments, including but not limited to the following: cardiac catheterization, angioplasty (balloon), stenting, and electroconversion.



3. Have you had any of the following tests performed: chest X-ray, CT scan, MRI, angiogram, EKG, echocardiogram, TEE (trans-esophageal echo), bleeding scan, endoscopy, lung bronchoscopy, carotid duplex/ultrasound, MRI/MRA of the head/neck, angiogram of the head or neck, CT scan of the head, echocardiogram, bubble/microbubble study, EKG, Holter monitor.

*If "yes," answer the following:*

L. Have you ever participated in any clinical trials or studies relating to any drugs or treatments for any medical conditions? Yes \_\_\_\_ No \_\_\_\_

If "yes," please identify:

1. Name of the trial or study: \_\_\_\_\_
2. Sponsor of trial or study: \_\_\_\_\_
3. Drug or treatment studied: \_\_\_\_\_
4. Purpose of the drug or treatment studied: \_\_\_\_\_
5. Name and address of the investigator in charge of your care and treatment in the trial or study: \_\_\_\_\_  
\_\_\_\_\_
6. The dates you participated in the trial or study: \_\_\_\_\_

**VII. WAGE LOSS INFORMATION AND OTHER MONETARY LOSS CLAIMS**

A. Are you making a claim for loss of wages? Yes \_\_\_\_ No \_\_\_\_

If "no," then go to Section VII (B).

1. State the total amount of time you have lost from work as a result of any condition that you claim or believe was caused by your use of Vioxx and the amount of income that you claim you lost. \_\_\_\_\_  
\_\_\_\_\_
2. State your total earned income (including salary, bonus, and benefits) for each of the last ten (10) years.

Year	Income
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

\_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_

B. Have you paid or incurred any medical expenses that are related to any condition that you claim or believe was caused by your use of Vioxx and for which you seek recovery in the action you have filed?  
Yes \_\_\_\_ No \_\_\_\_

If "yes," state the total amount of such expenses at this time: \$ \_\_\_\_\_

C. Has your insurer, or any other entity or person, paid or incurred any medical expenses that are related to any condition that you claim or believe was caused by your use of Vioxx and for which you seek recovery in the action you have filed?  
Yes \_\_\_\_ No \_\_\_\_

If "yes," state the total amount of such expenses at this time: \$ \_\_\_\_\_

D. Please provide an itemized statement of the nature and amount of damages you are claiming. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

E. Please identify all persons not identified elsewhere in this ASPPF who you believe possess information relevant to your claims in this matter and for each, state his or her name, address, telephone number and a description of the information you believe he or she possesses.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**VIII. PERSONAL INFORMATION OF LOSS OF CONSORTIUM**

*If you are a representative or loss of consortium plaintiff, please provide your personal responses to these questions.*

A. Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Middle Name or Initial: \_\_\_\_\_

B. Any other names used or by which you have been known, including but not limited to maiden name: \_\_\_\_\_

C. Social Security Number: \_\_\_\_\_

D. Driver's license number: \_\_\_\_\_ State issuing your license: \_\_\_\_\_

E. Date and place of birth: \_\_\_\_\_

F. Sex: Male \_\_\_\_ Female \_\_\_\_

G. Current street address and date began residing at this address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
City State Zip Code

H. Identify each other address at which you have resided during the last ten (10) years, and list when you started and stopped living at each one:

[Redacted Header]		



- I. Identify each high school, college, university or other educational institution (except grade school) you have attended, the dates of attendance, courses of study pursued, and diplomas or degrees awarded:

[Redacted Header]			

J. Employment Information.

Current employer (if not currently employed, last employer):

Name \_\_\_\_\_

Address \_\_\_\_\_

Dates of employment \_\_\_\_\_

Occupation/Job duties \_\_\_\_\_

K. Date and place of marriage: \_\_\_\_\_

L. Have you ever been convicted or plead guilty of a crime? Yes \_\_\_ No \_\_\_

If "yes," where, when, and the crime: \_\_\_\_\_

**IX. LIST OF MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION**

EACH PLAINTIFF IS REQUIRED TO PRODUCE ALL MEDICAL RECORDS FROM ALL HEALTHCARE PROVIDERS WHOSE IDENTITY IS REQUESTED BELOW PURSUANT TO (a) SECTION II.(A).(4) OF THE POST 11.09 PLAINTIFFS' ORDER, REGARDLESS OF WHETHER PLAINTIFF IS REQUIRED TO RESPOND TO THIS AMENDED AND SUPPLEMENTAL PROFILE FORM UNDER SECTION II(A)(4), AND (b) SECTION II(A)(4) OF THE PRE 11.09 PLAINTIFFS' ORDER.

List the following:

A. Your current family and/or primary care physician:

Name	Address	Approximate Dates of Treatment	
		From:	To:

B. To the best of your ability, identify each of your *other* family and/or primary care physicians from 1995 to the present.

Name	Address	Approximate Dates of Treatment	
		From:	To:

C. Each hospital, clinic, or healthcare facility where you have received inpatient treatment or been admitted as a patient from 1995 to the present.

Name	Address	Admission Dates	Reason for Admission

D. Each hospital, clinic, or healthcare facility where you have received outpatient treatment (including treatment in an emergency room) from 1995 to the present.

Name	Address	Treatment Dates	Reason for Treatment

E. Each physician or healthcare provider, not already listed in Sections IX (A) and IX (B) above, from whom you have received treatment from 1995 to the present.

Name	Address	Specialty	Approximate Dates of Treatment	
			From:	To:

F. Each pharmacy that has dispensed medication to you from 1995 to the present.

Name	Address	Approximate Dates Pharmacy Used	
		From:	To:

**X. DOCUMENTS AND THINGS**

Please indicate if any of the following documents and things are currently in your possession, custody, or control, or in the possession, custody, or control of your lawyers by checking "yes" or "no." Where you have indicated "yes," please attach the documents and things to your responses to this fact sheet. If not attached, please indicate why not.

- A. A copy of all prescriptions for Vioxx, receipts, physician or office records, drug containers, packaging and other records that show the period during which you have taken Vioxx, the dosage of Vioxx and the frequency with which you took Vioxx.  
Yes \_\_\_ No \_\_\_
- B. If you have been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding.  
Yes \_\_\_ No \_\_\_
- C. All diagnostic tests or test results for any disease, illness or conditions as detailed in this PPF.  
Yes \_\_\_ No \_\_\_
- D. Copies of all documents from physicians or other healthcare providers identified in this PPF.  
Yes \_\_\_ No \_\_\_
- E. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, pharmacy handouts or other materials distributed or provided to you when your prescriptions for Vioxx were filled.  
Yes \_\_\_ No \_\_\_
- F. Copies of all advertisements or promotions for Vioxx received or seen before filing this action.  
Yes \_\_\_ No \_\_\_
- G. Executed authorizations signed and undated in the forms appended hereto, in following manner:
- If you are claiming damages for lost earnings or earning capacity, execute authorization forms #s 1-5 as provided on the court's website at <http://vioxx.laed.uscourts.gov/Forms/Forms.htm>
  - If you are not claiming damages for lost earnings or earning capacity, execute authorization forms #s 1-3 and #5 as provided on the court's website at <http://vioxx.laed.uscourts.gov/Forms/Forms.htm>
- H. If you claim you have suffered loss of earnings or earning capacity, all documents that evidence your income/earnings for each of the last ten (10) years.  
Yes \_\_\_ No \_\_\_

- I. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider and statements and explanations of benefits from your health care insurer or plan.  
Yes \_\_\_\_ No \_\_\_\_
- J. Copy of all written communications, whether written or electronic (including email, communications as part of internet "chat rooms" or e-mail groups), with others not including your counsel, regarding Vioxx, your injuries or this case.  
Yes \_\_\_\_ No \_\_\_\_
- K. Copies of letters testamentary, letters of administration, powers of attorney, guardianship or guardian *ad litem* orders or other documents relating to your status as plaintiff if you are suing and/or are completing this PPF and the Authorizations on behalf of another individual.  
Yes \_\_\_\_ No \_\_\_\_
- L. Decedent's death certificate (in death case).  
Yes \_\_\_\_ No \_\_\_\_
- M. Report of autopsy of decedent (in death case).  
Yes \_\_\_\_ No \_\_\_\_
- N. All photographs, drawings, slides, movies, day-in-the-life films, or videotapes, edited and unedited, taken by anyone, in your possession, the possession of your attorney or experts, or any other person acting on your behalf, relating to plaintiff's injuries, limitations or damages, and which are not privileged work product or otherwise not discoverable.  
Yes \_\_\_\_ No \_\_\_\_
- O. All documents relating to Vioxx in plaintiff's possession or control that were generated, published or disseminated by or obtained from Merck, whether or not it originated at Merck, that were in plaintiff's possession prior to the date on which plaintiff filed his/her Complaint in this action.  
Yes \_\_\_\_ No \_\_\_\_
- P. All documents in plaintiff's possession or control, prior to the date on which plaintiff filed his/her Complaint in this action, discussing alleged risks of Vioxx or any other COX-2 inhibitor drugs, or any alleged health impact, including, but not limited to, newspaper articles, scientific studies, health and fitness publications, union or other organizational newsletters, bulletins, or brochures.  
Yes \_\_\_\_ No \_\_\_\_
- Q. All documents in plaintiff's possession or control, prior to the date on which plaintiff filed his/her Complaint in this action, concerning any guidelines, procedures, requirements, recommendations, protocols, instructions, warnings or precautions for the use of Vioxx or any other COX-2 inhibitor drugs.  
Yes \_\_\_\_ No \_\_\_\_
- R. All documents in plaintiff's possession or control, prior to the date on which plaintiff filed his/her Complaint in this action, relating to any support or information group,

including internet sources, concerning Vioxx or any other COX-2 inhibitor drugs, including, but not limited to, communications from you, or received by you from such groups concerning Vioxx or other COX-2 inhibitor drugs.

Yes \_\_\_\_\_ No \_\_\_\_\_

- S. All documents in plaintiff's possession or control, prior to the date on which plaintiff filed his/her Complaint in this action, concerning Vioxx or any other COX-2 inhibitor drugs distributed by public or private organizations, including without limitation, the American Nursing Association, the Food and Drug Administration, the Center for Disease Control, the American Medical Association, the American Heart Association, the National Institutes of Health, the Occupational Safety and Health Administration, or NIOSH.

Yes \_\_\_\_\_ No \_\_\_\_\_

- T. Any videotape or sound recordings that have been broadcast on television or radio, or any newspaper, magazine or other published document wherein plaintiff has discussed Vioxx or any aspect of the alleged incident or injury that forms the basis of this action.

Yes \_\_\_\_\_ No \_\_\_\_\_

- U. Any and all product insert data sheets, marketing materials, promotional materials, advertisements, packaging information, labels, bottles, boxes, samples, labeling fact sheets or informational sheets provided to plaintiff by any prescribing physician, pharmacy or other healthcare provider, or any other materials provided by any prescribing physician, pharmacy, or other healthcare provider, or anyone else prior to the date on which plaintiff filed his/her Complaint in this action, and relating to Vioxx, CELEBREX®, or BEXTRA®.

Yes \_\_\_\_\_ No \_\_\_\_\_

- V. Each and every document in plaintiff's possession or control, prior to the date on which plaintiff filed his/her Complaint in this action, including but not limited to magazine or newspaper articles, brochures, material from internet sites, videotapes (including videotapes of news or other television programs), or audiotapes (including tapes of news or other radio or television programs), that mentions, refers to or relates to Vioxx and that was made available to plaintiff or reviewed by plaintiff prior to ingesting Vioxx.

Yes \_\_\_\_\_ No \_\_\_\_\_

- W. All non-privileged documents reflecting communications between plaintiff and any other person or entity, prior to the date on which plaintiff filed his/her Complaint in this action, and relating to, referring to, or regarding the allegations of the Complaint, Merck, Vioxx or any injury you claim resulted from plaintiff's use of, or exposure to, Vioxx.

Yes \_\_\_\_\_ No \_\_\_\_\_

- X. Each and every document that evidences any communication between plaintiff and any doctor, any employer, any defendant, any federal or state agency, or any other person (other than your attorney) regarding the incident made the basis of this suit or your claims in this lawsuit.

Yes \_\_\_\_\_ No \_\_\_\_\_

Y. All entries in personal diaries, calendars, journals, logs, appointment books, date books, or similar materials plaintiff kept or continues to keep from January 1, 1995 to the present which relate or refer to plaintiff's medical care, medical condition, or employment and not prepared at the direction of your attorney.

Yes \_\_\_\_\_ No \_\_\_\_\_

Z. Have you prepared personal diaries, calendars, journals, logs, appointment books, date books, or similar materials at the direction of your attorney(s)?

Yes \_\_\_\_\_ No \_\_\_\_\_



**ADDITIONAL INFORMATION**

**ADDITIONAL INFORMATION**

**CERTIFICATION**

I certify under penalty of perjury that all of the information provided in this Amended and Supplemental Plaintiff Profile Form is true and correct to the best of my knowledge, that I have completed the List of Medical Providers and Other Sources of Information appended hereto, which is true and correct to the best of my knowledge, that I have supplied all the documents requested in part X 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 authorizations attached to this declaration. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name  
(Loss of Consortium Plaintiff)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

SUPERIOR COURT OF NEW JERSEY  
LAW DIVISION: ATLANTIC COUNTY

In re: VIOXX® LITIGATION

Case No. 619

**AUTHORIZATION FOR RELEASE OF  
MEDICAL RECORDS PURSUANT TO  
45 C.F.R. § 164.508 (HIPAA)**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to release all existing medical records regarding the above-named person's medical care, treatment, physical condition, and/or medical expenses to the law firm of **DECHERT LLP, P.O. Box 5218, Princeton, New Jersey 08543-5218 and/or HUGHES HUBBARD & REED LLP, 101 Hudson Street, Jersey City, New Jersey 07302-3918 or their designated agent(s) ("Receiving Parties")**. These records shall be used or disclosed solely in connection with the currently pending VIOXX® litigation involving the person named above. This authorization shall cease to be effective as of the date on which the above-named person's VIOXX® litigation concludes. The Receiving Parties shall return or destroy the protected health information (including all copies made) at the end of the above-named person's litigation or proceeding.

I understand that the health information being used/disclosed may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

This authorization also may include x-ray reports, CT scan reports, MRI scans, EEGs, EKGs, sonograms, arteriograms, discharge summaries, photographs, surgery consent forms, admission and discharge records, operation records, doctor and nurses notes (excluding psychotherapy notes maintained separately from the individual's medical record that document or analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session by referring to something other than medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress), prescriptions, medical bills, invoices, histories, diagnoses, narratives, and any correspondence/memoranda and billing information. It also includes, to the extent such records currently exist and are in your possession, insurance records, including Medicare/Medicaid and other public assistance claims, applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other documents or things

pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, etc.). This listing is not meant to be exclusive.

This will further authorize you to provide updated medical records, x-rays, reports or copies thereof to the above attorney until the conclusion of the litigation. I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation. I further reserve the right to request the return or redaction of sensitive or embarrassing information, not germane to the litigation, that is disclosed to the Receiving Parties.

This authorization is being forward by, or on behalf of, attorneys for the defendant. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of Hughes, Hubbard & Reed LLP or Dechert LLP.

Dated this \_\_ day of \_\_\_\_\_, 200\_\_

[PLAINTIFF OR REPRESENTATIVE]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:

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SUPERIOR COURT OF NEW JERSEY  
LAW DIVISION: ATLANTIC COUNTY

In re: VIOXX® LITIGATION

Case No. 619

**AUTHORIZATION FOR RELEASE OF  
PSYCHOLOGICAL/PSYCHIATRIC  
RECORDS PURSUANT TO  
45 C.F.R. § 164.508 (HIPAA)**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to release all existing records regarding the above-named person's psychological or psychiatric care, treatment, condition, and/or expenses to the law firm of DECHERT LLP, P.O. Box 5218, Princeton, New Jersey 08543-5218 and/or HUGHES HUBBARD & REED LLP, 101 Hudson Street, Jersey City, New Jersey 07302-3918 or their designated agents ("Receiving Parties"). These records shall be used or disclosed solely in connection with the currently pending VIOXX® litigation involving the person named above. This authorization shall cease to be effective as of the date on which the above-named person's VIOXX® litigation concludes. The Receiving Parties shall return or destroy the protected health information (including all copies made) at the end of the above-named person's litigation or proceeding.

I understand that this authorization includes information regarding the diagnosis and treatment of psychiatric and psychological disorders, and that the health information being used/disclosed may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

This authorization also may include x-ray reports, CT scan reports, MRI scans, EEGs, EKGs, sonograms, arteriograms, discharge summaries, photographs, surgery consent forms, admission and discharge records, operation records, doctor and nurses notes (excluding psychotherapy notes maintained separately from the individual's medical record that document or analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session by referring to something other than medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress), prescriptions, medical bills, invoices, histories, diagnoses, psychiatric treatment and counseling records, psychological treatment and counseling records, narratives, and any correspondence/memoranda and billing information. It also includes, to the extent such records currently exist and are in your

possession, insurance records, including Medicare/Medicaid and other public assistance claims, applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, etc.). This listing is not meant to be exclusive.

This will further authorize you to provide updated medical records, x-rays, reports or copies thereof to the above attorney until the conclusion of the litigation. I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation. I further reserve the right to request the return or redaction of sensitive or embarrassing information, not germane to the litigation, that is disclosed to the Receiving Parties.

This authorization is being forward by, or on behalf of, attorneys for the defendant. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of Hughes, Hubbard & Reed LLP or Dechert LLP.

Dated this \_\_\_ day of \_\_\_\_\_, 200\_\_

**[PLAINTIFF OR REPRESENTATIVE]**

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:

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SUPERIOR COURT OF NEW JERSEY  
LAW DIVISION: ATLANTIC COUNTY

In re: VIOXX® LITIGATION

Case No. 619

**AUTHORIZATION FOR RELEASE OF  
PSYCHOTHERAPY NOTES PURSUANT  
TO 45 C.F.R. § 164.508 (HIPAA)**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to release all existing psychotherapy notes regarding the above-named person's medical care, treatment, physical/mental condition, and/or medical expenses to the law firm of **DECHERT LLP, P.O. Box 5218, Princeton, New Jersey 08543-5218 and/or HUGHES HUBBARD & REED LLP, 101 Hudson Street, Jersey City, New Jersey 07302-3918 or their designated agent(s) ("Receiving Parties")**. These records shall be used or disclosed solely in connection with the currently pending VIOXX® litigation involving the person named above. This authorization shall cease to be effective as of the date on which the above-named person's VIOXX® litigation concludes. The Receiving Parties shall return or destroy the protected health information (including all copies made) at the end of the above-named person's litigation or proceeding.

I understand that this authorization includes all psychotherapy notes maintained separately from the above-named person's medical record that document or analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session by referring to something other than medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress.

I understand that the health information being disclosed by these psychotherapy notes may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

This will further authorize you to provide updated medical records, x-rays, reports or copies thereof to the above attorney until the conclusion of the litigation. I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition of obtaining insurance



coverage. I further understand that the above-named facility or provider cannot condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation. I further reserve the right to request the return or redaction of sensitive or embarrassing information, not germane to the litigation, that is disclosed to the Receiving Parties.

This authorization is being forward by, or on behalf of, attorneys for the defendant. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of Hughes, Hubbard & Reed LLP or Dechert LLP.

Dated this \_\_\_ day of \_\_\_\_\_, 200\_\_

[PLAINTIFF OR REPRESENTATIVE]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:

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# Exhibit B

**HUGHES HUBBARD & REED LLP**  
A New York Limited Liability Partnership  
101 Hudson Street, Suite 3601  
Jersey City, New Jersey 07302-3918  
(201) 536-9220

Attorneys for Defendant Merck & Co., Inc.

IN RE: VIOXX® LITIGATION

SUPERIOR COURT OF NEW JERSEY  
LAW DIVISION: ATLANTIC COUNTY

CASE NO. 619

CIVIL ACTION  
*APPLICABLE TO ALL CASES*

**THIS DOCUMENT RELATES TO:**

Plaintiff's Name:

Case Name:

Case Number:

**DEFENDANT MERCK & CO., INC.'S  
FIRST SET OF INTERROGATORIES TO PLAINTIFF**

Defendant Merck & Co., Inc. ("Merck"), by and through counsel,  
propounds on Plaintiff the following First Set of Interrogatories pursuant to N.J. Rule  
4:17. Plaintiff shall answer fully in writing and under oath within the applicable  
deadlines.

The following Definitions and Instructions are applicable and are  
expressly incorporated into these Interrogatories:

## DEFINITIONS AND INSTRUCTIONS

1. "Merck & Co., Inc." and "Merck" means any of the subsidiaries, divisions, departments, affiliates, predecessors, successors or offices of the defendant and by whatever name known, and all present and former officers, directors, employees, trustees, principals, agents, and representatives of Merck, as well as any person acting or purporting to act on its behalf.

2. "Plaintiff" or "you" or "your" or "yourself" means Plaintiff(s), any of his or her agents, representatives or assigns, as well as any person acting or purporting to act on his or her behalf.

3. "Vioxx®" means the prescription drug with the chemical name rofecoxib which is the subject of this lawsuit.

4. "Document" means any writing or record of any type, however produced and whatever the medium on which it was produced or reproduced, and includes, without limitation, the original and any non-identical copy (whether different from the original because of handwritten notes or underlying on the copy or otherwise) and all drafts of papers, letters, telegrams, telexes, notes, notations, memoranda of conversations or meeting, calendars, diaries, minutes of meetings, interoffice communications, electronic mail, message slips, notebooks, agreements, reports, articles, books, tables, charts, schedules, memoranda, medical records, x-rays, advertisements, pictures, photographs, films, accounting books or records, billings, credit card records, electrical or magnetic recordings or tapes, or any other writings, recordings, or pictures of any kind or description.

5. The term "communications" means all occasions on which information was conveyed from one person to another (a) by means of a document, or (b) verbally, including by means of a telephone or other mechanical or electronic device.

6. A response to a request contained in these Interrogatories to "identify" a document shall be sufficient if the individual having custody of the document is identified by name and address, and the document is identified or described by (a) the date, (b) the author, (c) the addressee(s), (d) the type of document (i.e., letter, memorandum, note, etc.), (e) the subject matter, and (f) the number of pages. In lieu of identifying a document, you may attach a copy of such document or documents to your answers to these Interrogatories.

7. A request to "identify" a person shall be construed as a request for (a) the full name of such person, (b) all other names which such person has used for him or herself, (c) the social security number of such person, (d) the date and place of birth of such person, (e) the present employer of such person, (f) the present office or business address and business telephone number of such person, (g) the present residential address and residential telephone number of such person, (h) the nature of the relationship between the plaintiff and such person, (i) the dates of commencement and termination of that relationship, and (j) the reason for the termination of that relationship. If you do not know or cannot determine the present address, telephone number or present employer of any person referred to in your answers to these Interrogatories, please give the last known address, telephone number or employer.

8. Throughout these interrogatories, including the definition of terms, words used in the masculine gender include the feminine; and words used in the singular include

the plural. Where the word "or" appears herein, the meaning intended is the logical inclusion "or" i.e., "and/or." Where the word "include" or "including" appears, the meaning intended is "including, but not limited to."

9. When requested to "state each fact" or the "facts upon which you rely" relating to any allegation, fact, legal theory, contention or denial, please furnish a full and complete statement of the factual basis of any such allegation, fact, legal theory, contention or denial, the reason or rationale that such facts so relate or pertain and how such facts so relate or pertain.

### **INTERROGATORIES**

#### **INTERROGATORY NO. 1**

Please identify, for the present civil action, the title of the action, the civil action number, the name of the court in which this action was filed, the name of the court in which this action is currently pending, and the full name, address, telephone number, and facsimile number of the principal attorney representing you in this action.

**ANSWER:**



**INTERROGATORY NO 2:**

Please identify each person having knowledge or information regarding the facts, circumstances, injuries, damages, or allegations contained in your Complaint.

**ANSWER:**

**INTERROGATORY NO. 3:**

Provide the factual basis and a computation for each category of damages you claim and identify all documents upon which you will rely in support of each category of damages.

**ANSWER:**

INTERROGATORY NO. 4:

Please state whether you have been reimbursed or filed a claim under an insurance policy with respect to alleged injuries that form the basis of this action. If so, for each claim, identify the person with whom you filed a claim, the insurer, the policyholder, the policy number, and the claim number.

ANSWER:

INTERROGATORY NO. 5:

State whether you have undergone a physical examination in connection with any application for life insurance since January 1, 1990. If so, state the date of any such examination, where it was conducted, who conducted the examination, whether there is a report of such physical examination and the life insurance company on whose behalf the examination was conducted. If a report was made, attach a true copy. If any such physical examination resulted in denial of your application, please describe such action.

ANSWER:

INTERROGATORY NO. 6:

Identify all information, instructions, warnings, or precautions about Vioxx obtained by you from any source. For each item of information, instruction, warning, or precaution, identify the source, the date you received it, and if you relied upon it in any manner, describe what action you took or did not take as a result.

ANSWER:

INTERROGATORY NO. 7:

State whether you have ever filed a claim (including a worker's compensation or a social security disability claim) or instituted a legal proceeding for any personal, economic or other injury. If so, state the date and nature of the injuries and damages claimed, the date and place of filing for each such claim or legal proceeding, the full names and addresses of all parties to the action and their attorneys, if any, the name of the court or other forum, the title of the action and the case number, and the present status of each claim or legal proceeding. If terminated, give the final result of each such claim or legal proceeding, including any monetary judgment, settlement or award.

ANSWER:

**INTERROGATORY NO. 8:**

Please identify whether you are in possession of any unused Vioxx. If so, please identify the number of tablets or amount of oral suspension in your possession, the date of the prescription to which the unused Vioxx relates, and the current location of the unused Vioxx.

**ANSWER:**

**INTERROGATORY NO. 9:**

Please identify all communications, whether oral, written or electronic (including email, communications as part of internet "chat rooms" or e-mail groups), with others not including your counsel, regarding Vioxx or your alleged injuries.

**ANSWER:**

**INTERROGATORY NO 10:**

Please identify whether you conducted any research on your computer regarding Vioxx, the current location of your computer, whether you ever sent and/or received any emails relating to Vioxx or your alleged injuries (other than those from your attorney), and whether you are in possession of the emails sent or received relating to Vioxx or your alleged injuries.

**ANSWER:**

**CERTIFICATION**

I hereby certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment for contempt of court.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

Dated: \_\_\_\_\_

Firm: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**HUGHES HUBBARD & REED LLP**  
A New York Limited Liability Partnership  
101 Hudson Street, Suite 3601  
Jersey City, New Jersey 07302-3918  
(201) 536-9220

Attorneys for Defendant Merck & Co., Inc.

IN RE: VIOXX<sup>®</sup> LITIGATION

SUPERIOR COURT OF NEW JERSEY  
LAW DIVISION: ATLANTIC COUNTY

CASE NO. 619

CIVIL ACTION  
*APPLICABLE TO ALL CASES*

**THIS DOCUMENT RELATES TO:**

Plaintiff's Name:

Case Name:

Case Number:

**DEFENDANT MERCK & CO., INC.'S  
FIRST SET OF INTERROGATORIES TO LOSS OF CONSORTIUM PLAINTIFF**

Defendant Merck & Co., Inc. ("Merck"), by and through counsel,  
propounds on Plaintiff the following First Set of Interrogatories pursuant to N.J. Rule of  
Civ. Pro. 4.17. Plaintiff shall answer fully in writing and under oath within the applicable  
deadlines.

The following Definitions and Instructions are applicable and are  
expressly incorporated into these Interrogatories:

## DEFINITIONS AND INSTRUCTIONS

1. "Merck & Co., Inc." and "Merck" means any of the subsidiaries, divisions, departments, affiliates, predecessors, successors or offices of the defendant and by whatever name known, and all present and former officers, directors, employees, trustees, principals, agents, and representatives of Merck, as well as any person acting or purporting to act on its behalf.

2. "Plaintiff" or "you" or "your" or "yourself" means Plaintiff(s) any of his or her agents, representatives or assigns, as well as any person acting or purporting to act on his or her behalf.

3. "Vioxx®" means the prescription drug with the chemical name rofecoxib which is the subject of this lawsuit.

4. "Document" means any writing or record of any type, however produced and whatever the medium on which it was produced or reproduced, and includes, without limitation, the original and any non-identical copy (whether different from the original because of handwritten notes or underlying on the copy or otherwise) and all drafts of papers, letters, telegrams, telexes, notes, notations, memoranda of conversations or meeting, calendars, diaries, minutes of meetings, interoffice communications, electronic mail, message slips, notebooks, agreements, reports, articles, books, tables, charts, schedules, memoranda, medical records, x-rays, advertisements, pictures, photographs, films, accounting books or records, billings, credit card records, electrical or magnetic recordings or tapes, or any other writings, recordings, or pictures of any kind or description.

5. The term "communications" means all occasions on which information was conveyed from one person to another (a) by means of a document, or (b) verbally, including by means of a telephone or other mechanical or electronic device.

6. A response to a request contained in these Interrogatories to "identify" a document shall be sufficient if the individual having custody of the document is identified by name and address, and the document is identified or described by (a) the date, (b) the author, (c) the addressee(s), (d) the type of document (i.e., letter, memorandum, note, etc.), (e) the subject matter, and (f) the number of pages. In lieu of identifying a document, you may attach a copy of such document or documents to your answers to these Interrogatories.

7. A request to "identify" a person shall be construed as a request for (a) the full name of such person, (b) all other names which such person has used for him or herself, (c) the social security number of such person, (d) the date and place of birth of such person, (e) the present employer of such person, (f) the present office or business address and business telephone number of such person, (g) the present residential address and residential telephone number of such person, (h) the nature of the relationship between the plaintiff and such person, (i) the dates of commencement and termination of that relationship, and (j) the reason for the termination of that relationship. If you do not know or cannot determine the present address, telephone number or present employer of any person referred to in your answers to these Interrogatories, please give the last known address, telephone number or employer.

8. Throughout these interrogatories, including the definition of terms, words used in the masculine gender include the feminine; and words used in the singular include



the plural. Where the word "or" appears herein, the meaning intended is the logical inclusion "or" i.e., "and/or" Where the word "include" or "including" appears, the meaning intended is "including, but not limited to."

9. When requested to "state each fact" or the "facts upon which you rely" relating to any allegation, fact, legal theory, contention or denial, please furnish a full and complete statement of the factual basis of any such allegation, fact, legal theory, contention or denial, the reason or rationale that such facts so relate or pertain and how such facts so relate or pertain.

### **INTERROGATORIES**

#### **INTERROGATORY NO. 1:**

With respect to your current marriage, please state the date and place of your marriage, whether you and/or your spouse have ever separated, legally or otherwise, for any period of time, and if so, please set forth the dates of separation and the reasons.

**ANSWER:**

**INTERROGATORY NO. 2:**

Please describe in detail each and every injury and damages (economic or otherwise) that you claim to have suffered in connection with your claim for loss of consortium. If you claim economic loss, please set forth the basis for your calculation of such loss.

**ANSWER:**

**INTERROGATORY NO 3:**

State all facts that support the computation of damages that you claim to have incurred as a result of your spouse's ingestion of Vioxx, and specifically identify all testimony, documents, and things that you rely upon for these computations.

**ANSWER:**

**INTERROGATORY NO. 4:**

Please identify all communications, whether oral, written or electronic (including email, communications as part of internet "chat rooms" or e-mail groups), with others not including your counsel, regarding Vioxx, your spouse's alleged injuries, your alleged injuries.

**ANSWER:**

**INTERROGATORY NO 5:**

Please identify whether you conducted any research on your computer regarding Vioxx, the current location of your computer, whether you ever sent and/or received any emails relating to Vioxx or your alleged injuries (other than those from your attorney) and whether you are in possession of the emails sent or received relating to Vioxx or your alleged injuries.

**ANSWER:**

**INTERROGATORY NO. 6:**

With respect to your current marriage, please state whether you and/or your spouse has ever sought counseling for marital problems or marital difficulties and if so, please identify the person from whom each of you sought counseling, the dates counseling was obtained, and the location where counseling was obtained. Please also provide a detailed description of the reasons for seeking counseling.

**ANSWER:**

**Certification**

**I hereby certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment for contempt of court.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

Dated: \_\_\_\_\_

Firm: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_