IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

Case No. 1:09-MD-XXXXX-XXXXX

IN RE DENTURE CREAM PRODUCTS
LIABILITY LITIGATION -- MDL-XXXX,

This Document Relates To All Actions

THIS RELATES TO MDL DOCKET XXXX

PLAINTIFF: Mitchell XXXXX
Name(s)

PLAINTIFF FACT SHEET

Please provide, to the best of your knowledge and ability, the following information for each individual on whose behalf a claim is being made. If you are completing this questionnaire in a representative capacity, please respond to the questions in sections I (A), I (B), and II through XIII with respect to the person by whom Denture Adhesive Cream was allegedly used ("Denture Adhesive Cream User" or "User"). In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. If you cannot recall or determine the exact date(s) requested, then please provide your best approximation. To the extent you recall details after you submit your fact sheet, you are obligated to supplement your fact sheet with the additional information. *Please attach as many additional sheets of paper as are necessary to fully and completely answer these questions.*

In filling out this form, please use the following definitions and instructions:

(1) "Health Care Provider" means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, nursing, dietary, and any pharmacy, x-ray department, laboratory, physical therapist or physical therapy department, radiologist or radiology group, dermatologist, surgeon, x-ray department or facility, rehabilitation specialist or facility, physician, osteopath, homeopath, chiropractor, podiatrist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you. "Health Care Provider" as defined herein does not include a purely "consulting expert" (as interpreted and defined by governing rules, and subject to the provisions and limitations of the Federal Rules of Civil Procedure) who: (1) has been specifically retained by your counsel in this Lawsuit to evaluate or diagnose your medical and/or mental condition; *and* (2) has not, outside of this retained role, ever been involved in your evaluation, diagnosis, care and/or treatment.

(2) "Oral Health Care Provider" means any dentist, oral surgeon, endodontist, periodontist, prosthodontist, denturist, orthodontist, dental hygienist, other provider of dental or

oral health care, as well as any dental office, facility or clinic that is associated with such persons.

(3) "Document" means any writing or record of every type that is in your possession, custody or control, including but not limited to written documents, documents in electronic format, cassettes, videotapes, photographs, charts, computer discs or tapes, x-rays, drawings, graphs, phone records, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form.

I. Case Information

Name of person completing this form:

A. Please state the following for the civil action that you filed:

1. Name of the Denture Adhesive Cream User: Mitchell XXXX

2. Case caption: Mitchell XXXXX Vs. YYYY, et al

3. Name, address, telephone number, fax number and e-mail address of principal attorney representing you:

XXXXX & YYYYY
Name

XXXX Law Firm
Firm

123 XXXX Avenue
Street Address

XXXX, XX, 00000
City, State and Zip Code

000-000-0000
Telephone Number

000-111-1111
Fax Number

xxxxx@xxxxxxx.com; xxxxxx@xxxxxx.com
E-mail address

B. If you are completing this questionnaire in a representative capacity (on behalf of the estate of a deceased person, incapacitated person, or a minor), please state:

1. Your name: N/A

2. Address: N/A

3. In what capacity you are representing the individual: N/A

4. If you were appointed by a court, state the court and date of appointment: N/A

5. Your relationship to deceased or represented person: N/A

6. If you represent a decedent's estate, state the date of death of decedent: N/A

II. Personal Data of the Denture Adhesive Cream User*

A. Maiden name or any other names used and dates of use: XXXX

B. Identify each address at which you have resided since 1995 to the present, starting with your current address, and list when you started and stopped living at each address:

Address	Dates of Residence
	2001
	2003
	2004
	2010

C. Driver's License Number and State Issuing License:

D. Social Security Number: XXX-XX-XXXX

E. Date and place of birth: MM/DD/YYYY

F. Sex: Male ✓ Female

G. For your current and each former marriage, please list the following information for each spouse:

Name and Current Address of Spouse, if known	Date of Birth	Date of Marriage, if Applicable	Date Marriage Ended, if Applicable	How Marriage Ended	Occupation (current spouse only)

* In sections II through XIV, the Denture Adhesive Cream User is also referred to as "User," "you" or "your."

H. Has your spouse filed a loss of consortium claim in this action? Yes_____ No_____

I. For each of your children, state his/her name, age, and state of residence:

J. Employment Information.

Beginning with your current employer (if not currently employed, last employer), list the following for each employer you have had since 1995 to the present:

Name	**Address**	**Dates of Employment**	**Job Title**
			Truck driver

K. Education. Please identify the schools you have attended (high school and beyond):

Name of School	**Address**	**Dates of Attendance**	**Degree or Diploma Awarded and Date Received**	**Major or Primary Field of Study**

L. Have you ever applied for worker's compensation, social security, or state or federal disability benefits? Yes _✓_ No_____

If "yes," then as to each application, separately state:

1. Date (or year) of application, type of benefits, and the reason for your claim: Worker's Compensation due to chemical bronchitis and Social Security Disability

2. Amount awarded or stated reason for denial, if denied:

3. To what agency or company did you submit your application (for example, Pennsylvania Division of Social Security):

M. Have you ever been out of work for more than thirty (30) days in any one (1) year for reasons related to your health condition (other than pregnancy)? Yes _✓_ No_____

If "yes," please state the dates you were out of work, your employer, if any, on those dates, and describe the condition(s) that kept you from working:

N. Have you ever served in the U.S. Military? Yes ____ No ✓

If "yes," were you ever rejected or discharged from military service for any stated reason relating to your health, physical, emotional or psychiatric condition? Yes_____ No_____

If "yes," describe the condition and the date upon which you were rejected or discharged from military service, and identify the military branch in which you were serving, or were considered for service, at that time.

O. Within the past 20 years, have you filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury, sickness or disease? Yes_____ No

If "yes," state the court in which such action was filed, the case name and/or names of adverse parties, and the civil action or docket number assigned to each such claim, action, or suit.

Have you *ever* filed a lawsuit or made a claim, other than in the present suit, relating to the same or similar injuries or conditions you claim in this case? Yes_____ No

If "yes," state the court in which such action was filed, the case name and/or names of adverse parties, and the civil action or docket number assigned to each such claim, action, or suit.

P. In the last 10 years, have you been convicted of or pled guilty to any felony and/or have you been convicted of or pled guilty to *any* crime that involved an alleged act of dishonesty or providing a false statement? [Rule 609 Federal Rules of Evidence] Yes_____ No

If "yes," state the date of such conviction or plea, the court in which such conviction or plea was entered and the nature of the felony and/or other crime.

III. Oral Health Care Providers of the Denture Adhesive Cream User

A. Please list to the best of your knowledge every Oral Health Care Provider (beginning with your *current* dentist) whom you have seen or from whom you have ever received oral or dental care or treatment (including fitting and treatment for dentures, repair and/or replacement of dentures) since 5 years before you first got denture(s) to the present. Please **circle** the Name of the Oral Health Care Provider that you ***last*** saw for any reason.

Full Name and Specialty, if any	Complete Address	Treatment Provided	Approximate Dates
Walter XXX, DDS, PA Jesse XXX, DDS		Teeth #s 5,6,18,20,21,28 extraction. Full upper and lower dentures	2001-2010

IV. Dentures

A. Use of Dentures

1. Reason you use dentures:
   a. Please describe in your own words why you need dentures (for example, an accident causing tooth loss (describe accident), loss of tooth enamel or bone, mouth or gum disease, lack of oral hygiene, or other reason).

   b. If any Oral Health Care Provider or Health Care Provider told you about a medical or oral condition requiring you to use dentures, please state the Provider's full name and address, the date(s) the Provider informed you, and what you were told by the Provider.

2. Please provide the following information for any tooth extraction done in preparation for denture use:

   a. Number of teeth extracted: 6

   b. Location of teeth extracted: #5, #6, #18, #20, #21, #28

   c. Name of Oral Health Care Provider or Health Care Provider performing extraction: Walter XXXX, DDS

   d. Date of extraction: 2001, 2002, 2003

3. Date of first use of dentures: 1992

4. Date of last use of dentures (if ongoing, please state): 09/2009

5. State the type of dentures you wear/have worn and the approximate beginning and ending dates you wore each: (a) uppers only; (b) lowers only; (c) both uppers and lowers ✓ ; (d) partials ✓ ; (e) other (please specify):

6. The last date you saw an Oral Health Care Provider *regarding your dentures* and the name of the Provider seen: 05/11/2010, Walter XXXX, DDS, PA

V. Denture Adhesive Creams

A. With respect to your use of *any* Denture Adhesive Cream at any time (including but not limited to Poligrip and/or Fixodent)

Please answer the following:

Brand *and* Type of each Denture Adhesive Used	**Date of First Use and Dates of Any Later Use**	**Name(s) of Oral Health Care Provider(s), if any, that you were seeing during the time period you indicate in Column 2**
Fixodent	1992 - 2009	Walter XXXX, DDS, PA

B. Prior to or during your use of any denture adhesive cream, were you given any information by any Oral Health Care Provider(s) or Health Care Provider(s) regarding use of denture adhesive cream (information may include oral or written instructions, directions, advice, warnings, or other types of information)? Yes_____ No

If yes, please state:

1. The date(s) on which such oral instructions, directions, advice, warnings, or other information regarding use of denture adhesive cream were given to you:

2. Name and address of any Oral Health Care Provider or Health Care Provider who gave the oral instructions, directions, advice, warnings or other information regarding use of denture adhesive cream to you:

3. To the best of your ability, describe what you were told about the use of denture adhesive cream by *each* Oral Health Care Provider or Health Care Provider you identified in 2 above.
Provider 1 [Name of Provider and Information Given]:

Provider 2 [Name of Provider and Information Given]:

Provider 3 [Name of Provider and Information Given]:

VI. Medical Background of the Denture Adhesive Cream User

A. General Background

1. Height: 5”7’

2. Current Weight: 218.6 Ibs

B. Smoking/Tobacco Use History

1. Ever smoked cigarettes? Yes No ✓

   a. If "yes," provide the date you started smoking:

2. Current smoker of cigarettes? Yes ___ No ✓

   a. If "yes," state the number of packs smoked per day:

3. Former smoker of cigarettes? Yes No ✓

   a. If "yes," provide the date you permanently stopped smoking:

   b. If "yes," state the number of packs smoked per day before you permanently stopped:

4. Any other form of tobacco use (pipe tobacco, snuff, chewing tobacco, dipping, and cigars)? Yes_____ No ✓

   a. If "yes," then state what form, dates of use, and amount of use as to each:

5. Has the number of cigarettes smoked per day or other daily tobacco use, changed over the last 5 years? Yes No ✓

   a. If "yes," then please briefly describe the change in usage of each:

C. Alcohol Consumption

1. Have you in the past drunk alcohol (beer, wine, whiskey, etc.)? Yes __ No ✓

   a. If "yes," provide the date you started consuming alcohol:

2. Do you currently drink alcohol? Yes ____ No ✓

   a. If yes, check below which best describes your alcohol consumption.

   ___ Less than 1 drink per week
   ___ Less than 1 drink per month
   ___ 1-5 drinks per week
   ___ 6-10 drinks per week
   ___ 10 or more drinks per week
   ___ 20-30 drinks per month
   ___ 30-40 drinks per month
   ___ Over 40 drinks per month

b. If you have ever but do not currently drink alcohol, check below which best describes your former alcohol consumption.

___ Less than 1 drink per week
___ Less than 1 drink per month
___ 1-5 drinks per week
___ 6-10 drinks per week
___ 10 or more drinks per week
___ 20-30 drinks per month
___ 30-40 drinks per month
___ Over 40 drinks per month

3. If you have ever but do not currently drink alcohol, provide the date you last consumed any alcohol:

4. Has your weekly or monthly alcohol consumption pattern changed over the last 5 years? Yes_____ No ✓

a. If "yes," then please describe the change:

D. Illicit Drugs

1. Have you ever used marijuana regularly (more than once a month) during a period of 3 or more consecutive months? Yes_____ No ✓ Don't Recall_____

a. If "yes," please state how often you used it, and the date of your last use:

2. Have you ever regularly used (more than once a month) any illicit drugs, other than marijuana, during a period of 3 or more consecutive months (examples include but are not limited to: cocaine/crack cocaine; heroin, opiates, or methadone; hallucinogens such as LSD, Ecstasy, ICE, PCP, MDMA or similar substances; amphetamines, crystal meth, or other stimulants; barbiturates or other sedatives)? Yes_____ No ✓

If "yes," please state what you used, how often you used it, and the date of your last use:

E. Nutritional History

1. Have you ever followed any special diets or dietary restrictions for more than 3 consecutive months, for example, for the purpose of weight loss, a health condition such as diabetes or high blood pressure, allergic reactions, or other reason? Yes ✓ No

If "yes," for each type of diet listed below, give a general description of the diet, the dates you followed that diet, the reason for the diet (for example, to lose weight; to control blood pressure, diabetes, or allergies; to correct nutritional or other imbalance), whether the diet was prescribed or recommended by a health care provider, and if so, the name of the health care provider.

a. Diet or nutritional program you designed yourself:

b. Physician-prescribed diet:

c. Any other diet program (examples include Adkins, South Beach, Pritikin, Jenny Craig, Weight Watchers, vegetarian, low fat, high protein, gluten free, etc.) -

2. Do you regularly drink soda or other carbonated beverages? Yes No ____

If "yes," please state the type of the soda you drink, whether diet or regular, and the amount of soda you drink per day.

F. To the best of your knowledge have you ever suffered from or been diagnosed by a doctor or other health care provider with:

No.	Condition/Disease	Yes	No	Don't Recall
1	Anemia	✓		
2	Leucopenia	✓		
3	Neutropenia	✓		
4	Hypocupremia or Copper Deficiency	✓		
5	Hyperzincemia or Zinc Overload	✓		
6	Vitamin B12 Deficiency	✓		
7	Other Vitamin Deficiency	✓		
8	Myelodysplasia		✓	
9	Myelofibrosis		✓	
10	Diabetes	✓		

No.	Condition/Disease	Yes	No	Don't Recall
11	Wilson's Disease		✓	
12	Menkes' Disease		✓	
13	Myasthenia Gravis		✓	
14	Multiple Sclerosis		✓	
15	Parkinson's Disease		✓	
16	Amyotropic Lateral Sclerosis (ALS; Lou Gehrig's Disease)		✓	
17	Alzheimer's Disease		✓	
18	Cancer/Malignancy		✓	
19	Uremia		✓	
20	Liver Disease		✓	
21	Rheumatoid Arthritis		✓	
22	Celiac Disease		✓	
23	Inflammatory Bowel Syndrome or Disease		✓	
24	Small Intestine/Bowel Bacterial Overgrowth		✓	
25	Other Malabsorption or Gastrointestinal Disorder		✓	
26	Short Bowel Syndrome		✓	
27	Gastric or Intestinal Ulcers		✓	
28	Aceruloplasminemia		✓	
29	Any Immunologic or Autoimmune disorder		✓	
30	Head, Neck, or Back Trauma or Injury		✓	
31	Brain Injury		✓	
32	Cognitive Deficits		✓	

No.	Condition/Disease	Yes	No	Don't Recall
33	Injury to Spinal Cord		✓	
34	Disease or injury of vertebra or disc		✓	
35	Occipital Horn Syndrome		✓	
36	Subacute Combined Degeneration of the Spinal Cord			
37	Myelopathy (disease or injury of spinal column)	✓		
38	Neuropathy or Peripheral Neuropathy (disease or injury to nerves other than spinal column)	✓		
39	Myeloneuropathy or Combined Systems Disease	✓		
40	Anorexia Nervosa		✓	
41	Bulimia Nervosa		✓	
42	Malnutrition		✓	
43	Any Neurologic (nerve) Disease or Disorder		✓	
44	Any Hematologic (blood) Disease or Disorder		✓	
45	Fibromyalgia		✓	
46	Asthma		✓	
47	Lumbar radiculopathy		✓	
48	Right Shoulder Bursitis		✓	
49	Acquired hypothyroidism	✓		
50	Proteinuria	✓		
51	Nephrolithiasis	✓		

No.	Condition/Disease	Yes	No	Don't Recall
52	Hematuria	✓		
53	Dumping Syndrome	✓		
54	Arthralgia	✓		
55	Numbness/Tingling/Loss of balance	✓		
56	Shortness of breath/dyspnea	✓		
57	Falls/Injury to lower extremity	✓		
58	Blurred vision	✓		
59	Depression	✓		
60	Memory Problems	✓		

If "yes," please state separately for each:

Type of Condition	Date of First Symptoms	Date of Diagnosis	Diagnosing Doctor
Anemia		12/27/2006	William XXXX, M.D.
Leucopenia		02/05/2007	John XXXX, M.D.
Neutropenia		03/14/2007	John XXXX, M.D.
Hypocupremia or Copper Deficiency		08/21/2009	Susan XXXX, M.D.
Vitamin B12 Deficiency		01/04/2007	William XXXX, M.D.
Other Vitamin Deficiency		02/09/2008	William XXXX, M.D.
Diabetes		12/13/2002	A. XXXX, M.D.
Myelopathy		07/16/2009	Susan XXXX, M.D.

Neuropathy or Peripheral Neuropathy		07/16/2009	Susan XXXX, M.D.
Myeloneuropathy or Combined Systems Disease		10/27/2009	Susan XXXX, M.D.
Acquired hypothyroidism		01/04/2007	William XXXX, M.D.
Proteinuria		12/26/2006	William XXXX, M.D.
Nephrolithiasis		03/13/2007	Brian XXXX, D.O
Hematuria		03/13/2007	Brian XXXX, D.O
Dumping Syndrome		03/23/2007	David XXXX, M.D.
Arthralgia		09/30/2003	David XXXX, M.D.
Numbness/Tingling/Loss of balance		10/08/2001	XXXX Chiropractic Network
Shortness of breath/dyspnea	02/04/2009	02/04/2009	Dwight XXXX, M.D.
Falls/Injury to lower extremity	02/18/2009	02/18/2009	Susan XXXX, M.D.
Blurred vision		11/17/2003	XXX Eye Care Center
Depression	04/07/2010	04/07/2010	Douglas XXXX, M.D.
Short-term memory loss	01/26/2007	01/26/2007	Brian XXXX, D.O.

G. Have you ever undergone dialysis, tube feeding, and/or intravenous feeding? If so, please provide the reason(s) for such treatment, and frequency and dates of such treatment:.

H. Have you ever had bariatric, gastrointestinal and/or other weight loss surgery? If so, please provide the reason(s) for the surgery, the date of the surgery, the name of the surgeon who performed the surgery, and the facility at which the surgery was performed:

Bariatric Surgery - morbid obesity - 01/05/2004 - Dr. David XXXX- xxxxx Regional Medical Center.

VII. Medications, Vitamins, or Supplements Used by the Denture Adhesive Cream User

To the best of your knowledge, state whether you used any of the following medications, vitamins or supplements at any time beginning 5 years before your first use of any denture adhesive cream to the present OR in the past 15 years, whichever date is earlier. Circle all medications you have used, state the first and last dates you took the medication, and identify the doctor that prescribed the medication, vitamins or supplements.

Medication	Dates Used (first to last use)	Prescribing Doctor, if Applicable	Reason for Use/Prescription, if applicable
Prednisone	01/14/1991	Jim XXXX, M.D.	Angioedema with wheezing
Proventil	01/14/1991	Jim XXXX, M.D.	Angioedema with wheezing
Hismanal	01/14/1991	Jim XXXX, M.D.	Angioedema with wheezing
Starlix	12/13/2002	A. XXXX, M.D.	Diabetes
Actos	12/20/2002	A. XXXX, M.D.	Diabetes
Synthroid	12/31/2003	David XXXX, M.D.	Hypothyroidism
Vitamin B-12	01/04/2007	William XXXX, M.D.	Low Vitamin B-12
Iron Supplements	01/04/2007	William XXXX, M.D.	Iron deficiency anemia
Lipitor	01/26/2007	Brian XXXX, DO	Nephrotic syndrome with hyperlipidemia
Lisinopril	01/26/2007	Brian XXXX, DO	Idiopathic nephrotic syndrome
Calcium +Vitamin D			
Norco	09/29/2009	William XXXX, M.D.	Low back pain
Repliva	02/05/2009		
Tums	02/05/2009		
Flovent Inhaler	02/05/2009		Dyspnea, inhalation injury
Copper Supplements	09/15/2009	Susan XXXX, M.D.	Decreased copper levels
Pravachol	10/28/2009	William XXXX, M.D.	Hypercholesterolemia
Augmentin	10/28/2009	William XXXX, M.D.	Upper Respiratory Infection
Cymbalta	04/07/2010	Douglas XXXX, M.D.	Depression
Lexapro	07/26/2010	William XXXX, M.D.	

VIII. Injuries, Symptoms, Diagnoses, Ailments, and Damages of the Denture Adhesive Cream User

A. Are you claiming that you have developed or may develop any injury or damage or condition (including any alleged physical, injury or damage) as a result of using denture adhesive cream? Yes _ No_____

If "yes," then for ***each*** such injury, damage or condition, answer the following:

1. Describe each injury, damage or condition that you are claiming was caused by your use of any Denture Adhesive Cream, including in your description the date you became aware of each injury, damage or condition and describe all of the symptoms you are experiencing that you claim result from use of denture adhesive cream.

Injury/Condition	**Date Became Aware of Injury/Condition**	**Symptoms**
Peripheral neuropathy	07/16/2007	Intermittent stocking glove numbness. Numbness and tingling in feet, balance problems, decreased night vision, memory problems, co-ordination problems
Myelopathy	07/16/2009	Severe truncal and lower limb ataxia, vibratory sensation was decreased more in the right leg and cold temperature sensation in the left leg
Anemia	01/04/2007	Fatigue, weakness, weight loss
Hypocupremia Hyperzincemia	01/26/2007	Decreased copper levels and increased zinc levels. Copper induced neuropathy, myelopathy. Hair loss or change in hair color. Malabsorption.

2. For each of the symptoms you describe in No. 1 above, going back ten (10) years from your first use of dentures, when was the ***first time*** (the earliest date) you can remember ever having that symptom, , even if the symptom went away

Symptom	**Earliest Date of Symptom**

3. For each such injury, damage, condition, or symptom that you have described in this Section VIII (A) (1-2) above, have you consulted with any Health Care Provider(s) or Oral Health Care Provider(s) with respect to your alleged denture adhesive cream-related injury(ies)? Yes No_____

If "yes," for each Health Care Provider or Oral Health Care Provider, state:

Name of Health Care Provider or Oral Health Care Provider	**Address of Health Care Provider or Oral Health Care Provider**	**Dates of Consultation/Treatment and Nature of Injury, Damage, Condition or Symptom**
William XXXX	Provider Name Address, City State Zip	09/15/2008 - Gastrointestinal-Heart burn, Musculoskeletal - Arthralgias, integumentary - felt like skin was crawling at times causing him to itch, neurological - dizziness 10/13/2008 - Falls, losing balance at times 07/26/2010 - Constipation, dry skin, hair loss, weight gain and fatigue
Susan XXXX, M.D.	Provider Name Address, City State Zip	02/18/2009 - Pain, numbness and tingling in extremities 04/20/2009 - Idiopathic peripheral neuropathy 06/23/2009 - Balance/walking and hand tremors 07/16/2009 - Peripheral neuropathy 08/17/2009 - Peripheral neuropathy, falls 09/15/2009 (phone call) - Neuropathy, decreased copper 10/27/2009 - Myelopathy in combined System Degeneration 12/28/2009 - Myelopathy in combined system degeneration secondary to copper deficiency 01/06/2010 - Myelopathy in combined system degeneration secondary to copper deficiency 02/17/2010 - Idiopathic peripheral neuropathy 08/18/2010 - Myelopathy in combined system degeneration secondary to copper deficiency

B. Did you ever suffer from these types of injuries, damages, or conditions, or have any symptoms of these types of injuries, damages, or conditions, prior to your use of denture adhesive cream? Yes_____ No

If "yes," for each such injury, damage, condition or symptom, state:

Description of Injury, Damage, Condition or Symptom	**Date(s) You Had the Injury, Damage, Condition or Symptoms**	**Health Care Provider or Oral Health Care Provider Visited, if Any**	**Dates of Consultation/Treatment with Health Care Provider or Oral Health Care Provider, if any**

C. Have you ever undergone any of the following medical tests?

1. Magnetic Resonance Imaging (MRI) of the brain: Yes ✓ No_____
2. Magnetic Resonance Imaging (MRI) of the spine: Yes_ No_____
3. Electromyogram (EMG): Yes✓ No_____ Unsure _____
4. Evoked Potentials Tests (including but not limited to Somatosensory Evoked Potentials (SSEP) tests): Yes_____ No_ Unsure _____
5. Nerve Conduction Velocity Study (NCVS): Yes✓ No_____ Unsure_____

If "yes" to any of the above, please state for *each*:

Name of Test	**Date Ordered**	**Ordering Physician**	**Test Results**	**Location of Test**
MRI Brain	07/16/2009	Susan XXXX, M.D.	Negative MRI of the brain	XXXX Radiologists Group
EMG and NCV	02/18/2009	Susan XXXX, M.D.	Sensorimotor axonopathy affecting the lower greater than upper limbs, with fibs and positive sharps appearing in a distal to proximal gradient in the lower	XXXX Neurology

Name of Test	Date Ordered	Ordering Physician	Test Results	Location of Test
			limbs	
	07/16/2009	Susan XXXX, M.D.	Compared to the study of February, 2009, there had been modest but definite improvements of the severe, axonal polyneuropathy with evidence of early Reinnervation and remodeling on needle EMG	XXXX Neurology
	01/06/2010	Susan XXXX, M.D.	The study showed worsening of the motor and sensory conduction velocities, but improvement buy needle EMG of the right lower limb, of his severe, sensorimotor polyneuropathy, when compared to the studies of February and June, 2009. Needle EMG of upper limb was not done previously	XXXX Neurology
	08/18/2010	Susan XXXX, M.D.	Improvement of all the sensory nerves in the upper limbs compared to the previous aforementioned studies, but no improvement in the motor nerves. These continue to be fibrillation potentials in the peroneal-innervated muscles on the right and in the right First Dorsal Interosseus and Abductor Pollicis Brevis. There was no worsening of a mild right ulnar conduction block compared to the study in January, 2010	XXXX Neurology

D. Do you allege that the use of denture adhesive cream aggravated a pre-existing condition? Yes_____ No_____

If "yes," for each such pre-existing condition, state:

a. A Description of the Pre-Existing Condition:

b. The date when any pre-existing condition first arose:

c. The date any pre-existing condition was first diagnosed:

d. The name and address of any healthcare provider or oral health care provider who provided care for any pre-existing condition:

E. Have you ever had laboratory work performed that measured your whole blood, serum, plasma, or urine levels for zinc, copper and/or ceruloplasmin? Yes ✓ No__ Unsure _____

If "yes," then based on your best recollection, separately state for zinc, copper and/or ceruloplasmin *each* time they were measured:

Name/Type of Test with zinc/copper levels	**Result**	**Date of Test**	**Facility**
Zinc, plasma/serum	Normal	08/21/2009	XXXX Regional Medical Center
Copper, plasma/serum	Low - 7	08/21/2009	XXXX Regional Medical Center
Zinc, plasma/serum	Normal	01/20/2010	XXXX Regional Medical Center
Copper, plasma/serum	Normal	01/20/2010	XXXX Regional Medical Center
Copper, Zinc	Copper – Low Zinc – High Zn/Cu - High	03/04/2010	

F. Has any Health Care Provider or Oral Health Care Provider told you, your agents, representatives or anyone acting on your behalf, orally or in writing, that any of the injuries, damages, conditions, or symptoms that you describe in this Section VIII above are associated with your use of any denture adhesive cream? Yes ✓ No_____

If "yes," then state and describe:

1. What you (or your agents, representatives or anyone acting on your behalf) were told: **Decrease Zinc (Fixodent toothpaste source) as this might decrease copper as well (High levels of oxygenous zinc)**

2. (a) The name(s) of the Health Care Provider or Oral Health Care Provider who told you (or your agents, representatives or anyone acting on your behalf) and (b) when: **Susan XXXX, M.D. on 09/15/2009**

G. Has any Health Care Provider or Oral Health Care Provider ever told you, your agents, representatives or anyone acting on your behalf, orally or in writing, that any of the injuries, damages or conditions that you describe in this Section VIII above are associated with any factors *other than* your use of any denture adhesive cream? Yes_____ No_____

If "yes," then state and describe:

1. What you (or your agents, representatives or anyone acting on your behalf) were told:

2. (a) The name(s) of the Health Care Provider or Oral Health Care Provider who told you (or your agents, representatives or anyone acting on your behalf) and (b) when:

H. Excluding future medical expenses are you claiming that you have paid or will have to pay any expenses as a result of having used any denture adhesive cream? Yes_____ No_____

If "yes," then for each item separately identify:

Reason Expense was Incurred	**Amount of Fees or Expenses**	**Person or Company Paid or to be Paid**

I. Are you claiming to have suffered any mental anguish or emotional injury as a consequence of using any denture adhesive cream? Yes No_____

If "yes," have you received any counseling/care/treatment by any mental health care provider for the mental anguish or emotional injury you are claiming? Yes ____ No____

If "yes," then state:

The full name, address and specialty of each mental health care provider you have seen for the mental anguish or emotional injury you are claiming, and the approximate date(s) of any visits with each:

J. Do you claim psychological or psychiatric injury (other than the mental anguish or emotional distress described above) as a consequence of using any denture adhesive cream. Yes __✓_____ No _____

If "yes," have you received any counseling/care/treatment by any mental health care at any time for any psychological or psychiatric conditions? Yes _✓_____ No_____

If "yes," then state: Depressive disorder

The full name, address and specialty of each mental health care provider you have *ever seen for any reason* and the approximate date(s) of any visits with each: XXXX Regional Medical Center, Douglas XXXX, M.D., Richard XXXX, Ph.D

K. Fact Witnesses

Please identify all persons who you believe possess information concerning your claimed injury(ies) and damages other than your Healthcare Providers and/or Oral Healthcare Providers, and please state their name address and his/her/their relationship to you:

Name:

Address:

Relationship to you:

Name:

Address:

Relationship to you:

Name:

Address:

Relationship to you:

IX. Family History of the Denture Adhesive Cream User

A. To the best of your knowledge did any child, parent, sibling, or grandparent of the Denture Adhesive Cream User have any of the conditions or experiences identified in Section VI (F) beginning on page ____?

Yes ✓ No_____ Unsure _____

B. If "yes," or "unsure," then based on your best recollection, state separately for each: person the relationship to you, the type of health problem, and the date and cause of death (if applicable): Father died at the age of 78 because of myocardial infarction, mother died at the age of 66 from complications of diabetes mellitus, 3 siblings have diabetes mellitus, a child with bipolar disorder

X. Health Care Providers of the Denture Adhesive Cream User

A. Provide the requested information for each of the following Health Care Providers and health care facilities:

Beginning with your current family and/or primary care physician(s), please list your family and/or primary care physicians in the time period from 10 years preceding your first use of dentures to the present.

Name	Address	Approximate Dates

B. Provide the requested information for each hospital, clinic, or health care facility where you have received inpatient or outpatient treatment (including treatment in an emergency room) or been admitted as a patient during the time period from 10 years preceding your first use of dentures to the present.

Name	Address	Admission/ Treatment Dates	Reason for Admission/ Treatment	Treatment Received
A. XXXX, M.D.		12/13/2002 12/20/2002 01/06/2003	Diabetes Mellitus	Medications given
Walter XXXX, DDS, PA		04/02/2001 05/16/2002 08/11/2003 09/30/2003 04/01/2004 01/04/2010 05/11/2010	Dental Visit	Extraction of teeth, partial and complete dentures placement
XXXX Orthopedics		10/05/2009 10/21/2009 10/28/2009 11/25/2009 12/08/2009 12/11/2009 12/15/2009 12/17/2009	Lateral tibial plateau fracture Cold symptoms Knee stiffness, weakness, pain	Non-operative treatment. Medications given. Physical therapy

Name	Address	Admission/ Treatment Dates	Reason for Admission/ Treatment	Treatment Received
		12/22/2009 12/29/2009 12/31/2009 01/04/2010 01/05/2010 01/14/2010 01/15/2010 01/19/2010 01/22/2010 01/25/2010 01/26/2010 01/29/2010 02/01/2010 02/03/2010 02/05/2010 02/10/2010 02/12/2010 02/16/2010 02/19/2010 02/23/2010 02/25/2010 03/01/2010 04/19/2010 05/07/2010 05/10/2010 05/13/2010- 06/15/2010 07/14/2010	Internal fixation of right lateral condyle fracture	
XXX Hospital		09/04/2000	Blisters on left side of face, hair line behind left ear, foreign body-bottom right foot	Dressing was given
XXXX Laboratory		05/26/2000	Stress Test	
XXX Sports Medicine and Physical Therapy	0000 xxx Blvd, Suite 00, City, State Zip	03/05/2009 03/12/2009 03/16/2009	Numbness Balance problems	Physical Therapy
Susan XXX, M.D.	0000 xxx Blvd, Suite 00, City, State Zip	02/18/2009 04/20/2009 06/23/2009 07/16/2009 08/17/2009 09/15/2009	Leg numbness Poly neuropathy Peripheral neuropathy Myelopathy Ataxia B12 and copper	EMG and NCV MRI of brain Counseling B12 and Copper supplements Labs

Name	Address	Admission/ Treatment Dates	Reason for Admission/ Treatment	Treatment Received
		10/27/2009 12/28/2009 01/06/2010 02/17/2010 08/08/2010	deficiencies Combined System Degeneration Balance/Walking and hand tremors	Fall prevention discussed
XXXX Chiropractic Center		10/09/2001 - 10/19/2001 10/29/2010 - 11/07/2001 11/21/2001 11/28/2001 12/12/2000 11/06/2006 11/17/2006 12/19/2007 11/16/2006 11/20/2006 11/21/2006 11/22/2006 11/24/2006 - 12/26/2006 12/28/2006 01/05/2007 01/09/2007 01/16/2007 01/26/2007 02/05/2007 02/19/2007 03/05/2007 03/16/2007 03/30/2007 04/30/2007 05/17/2007	Neck, upper back pain Neck stiffness Tenderness of cervical and lumbar spine Right shoulder pain	Chiropractic treatment
XXX Radiologists Group	0000 xxx Blvd, Suite 00, City, State Zip	12/28/2006 03/23/2007 07/18/2009	Ultrasound, Radiology and MRI	
XXX Surgical, P.L.L.C. David XXX		07/31/2003 08/09/2003 09/30/2003 01/05/2004 03/23/2007 07/26/2007 01/15/2009 02/15/2009-	Fatigue, anemia, neutropenia, proteinuria, Morbid obesity Gastric bypass operation	Gastric banding

Name	Address	Admission/ Treatment Dates	Reason for Admission/ Treatment	Treatment Received
		06/25/2009 09/15/2009 01/30/2010		
Drs. XXXX & XXXX, P.A.		04/02/2001	Dental visit	Teeth Extraction
XXX Care Center		11/17/2003 11/05/2007 01/20/2010	Blurred vision	
XXXX Regional Medical Center		01/05/1991 05/15/2000 08/09/2003 12/31/2003 01/05/2004 01/06/2004 10/30/2005 02/05/2007 02/07/2007 02/08/2007 03/01/2007 03/08/2007 07/26/2007 01/24/2009 01/31/2009 02/01/2009 02/04/2009 02/05/2009 04/01/2009 04/13/2009 05/14/2009 08/21/2009 09/30/2009 10/03/2009 10/16/2009 11/16/2009 03/25/2010 04/07/2010 04/08/2010 04/09/2010 04/12/2010 04/15/2010 04/16/2010 04/22/2010 04/23/2010 04/29/2010	Chest discomfort Normocytic anemia Neutropenia Nephrotic syndrome Diabetes Dumping syndrome Nephrolithiasis Hypothyroidism Hyperlipidemia Neuropathy Fall injury to right knee due to loss of balance Cough, sore throat Pneumonia Dyspnea Shortness of breath Right ankle injury Acute depression	Medications given Lab work Radiology Percutaneous reduction and internal fixation

Name	Address	Admission/ Treatment Dates	Reason for Admission/ Treatment	Treatment Received
		07/16/2010 08/29/2010 09/09/2010 09/11/2010		
J. XXX, M.D.		02/06/2003 01/15/2004	Diabetes, hypercholesterolemia, hypertriglyceridemia	Medications Labs
Kenneth. XXXX, M.D		11/04/2009 11/05/2009 11/30/2009	Anemia	Labs
Home Care		10/23/2009 - 04/30/2010	Home care treatment	
Lab		12/27/2006 12/29/2006 03/06/2007 09/16/2008 03/28/2000 01/27/2007 01/30/2007 03/09/2007 03/10/2007 03/14/2007 07/17/2007 07/20/2007 08/11/2007 08/14/2007 08/15/2007 09/13/2007 12/10/2007 07/27/2010	Lab work	
XXXX Diagnostic Laboratories		04/25/2007 05/30/2007 02/01/2008 02/09/2008 01/29/2009 02/19/2009 02/25/2009 03/27/2007	Lab work	
William XXXX, M. D.		03/27/2000 02/28/2000 12/26/2006 01/04/2007 03/05/2007 09/15/2008	Hypothyroidism Proteinuria Musculoskeletal pain Low back pain	Medications given, labs ordered

Name	Address	Admission/ Treatment Dates	Reason for Admission/ Treatment	Treatment Received
		09/29/2008 10/13/2008 07/26/2010		
Richard XXXX, Ph.D.		10/29/2003	Psychological evaluation	
XXXX Nephrology Associates		01/26/2007 03/13/2007 07/16/2007 08/13/2007	Proteinuria Nephrolithiasis Hematuria	Medications Labs
XXXX Laboratory Network		12/25/2002 01/07/2003 02/07/2003 08/15/2003 01/12/2004	Lab work	
XXXX Health		02/26/2009 03/25/2009 05/01/2009 05/15/2009	Difficulty breathing, reproductive cough/wheezing	Bronchodilators, medications given

C. Provide the requested information for each surgery or operation that you have ever undergone, including oral surgery but not including surgery related to childbirth.

Name and Address of Hospital, Treating Physician and Surgeon	Type of Surgery or Operation	Date of Surgery or Operation	Reason for Surgery or Operation

D. Provide the information requested for every other Health Care Provider (as defined at beginning of this questionnaire) or facility (not identified in A-C above) whom you have seen or consulted or from whom you have received treatment, evaluation, or testing for *any* reason, or at which you've been treated, evaluated or tested for *any r*eason, during the time period of 10 years preceding your first use of dentures to the present.

Name and Specialty, if any	Address	Dates of Treatment/ Admission/ Visit	Reason for Treatment/ Admission/Visit	Treatment Received

E. Provide the requested information for each pharmacy that has dispensed medication to you for the time period of 10 years preceding your first use of dentures to the present:

Name	**Address**	**Years When You Used Pharmacy**

XI. Insurance Providers of the Denture Adhesive Cream User

A. Have you ever had health, prescription, dental, disability, or worker's compensation insurance coverage at any time? Yes ____ No _____

If "yes," then as to each insurance provider, please provide:

Insurance Provider Name and Address/ Telephone Number, if Available	**Name and Address of Policy Holder/Insured (if different than you)**	**Subscriber/ Group ID Number and Policy/ Identification Number**	**Approximate Dates of Coverage**	**Type of Coverage (e.g., health, dental, comp)**

B. Have you ever been denied health, dental, or disability insurance coverage? Yes_____ No_____

If "yes," state the date of such denial, the name of the insurance company, and the stated reason for such denial, if known.

C. Have you ever been denied life insurance? Yes_____ No_____

If "yes," state the date of such denial, the name of the insurance company, and the stated reason for such denial, if known.

XII. Use of Poligrip

If you have used Poligrip denture adhesive cream at any time, please answer the following questions. If not, please leave blank.

A. Date of first use of Poligrip:

B. Date of last use of Poligrip (if ongoing, please state):

C. If you have discontinued your use of Poligrip, state the reason you stopped using Poligrip:

1. If you discontinued your use of Poligrip, were you advised to stop using Poligrip by a Health Care Provider or Oral Health Care Provider? Yes _____ No_____

2. If you answered yes above, state the name of the Provider and the approximate date you were so advised:

D. Did you use Poligrip continuously during the time period described in (A) and (B) above?

E. If you did not use Poligrip continuously, state the dates or time periods you used Poligrip:

F. The type(s) of Poligrip you normally use or used (for example, Super Poligrip Original, Super Poligrip Free, Super Poligrip Ultra Fresh, Super Poligrip Extra Care with Poliseal, or other):

G. The tube size of Poligrip you normally purchase or purchased (for example, 2.4 oz [68g], 1.4 oz [40g], or other):

H. If you have used more than one type of Poligrip, state the type of Poligrip and the approximate dates or time periods of use of each:

I. The number of times per week you use/used Poligrip (and, if different over time, describe and provide the dates or time periods of each such usage):

J. For your ***upper*** denture, the number of times per day you apply/applied Poligrip to your upper dentures (and, if different over time, describe and provide the dates or time periods of each such usage):

K. For your ***lower*** denture, the number of times per day you apply/applied Poligrip to your lower dentures (and, if different over time, describe and provide the dates or time periods of each such usage):

L. Did you or do you clean your dentures before each application of Poligrip? Yes No Sometimes ___

1. If you answered yes or sometimes, please describe your denture cleaning process:

M. Do you have other dental appliance(s) (for example, bridge, plate, mouth guard, crown) to which you applied/apply Poligrip? Yes__ No__

1. If yes, please identify the appliance(s) and the number of times per day that you use Poligrip with each appliance:

N. Every store or pharmacy where Poligrip was purchased by you or on your behalf and the approximate dates of purchase:

O. Identify every Oral Health Care Provider from whom you received Poligrip:

P. The number of 2.4 oz tubes of Poligrip you use/used in *each* of the following time periods: [Answer each subpart separately]

1. one week:

2. one month:

3. 6 months:

4. 1 year:

5. Other (for example, one 2.4 oz tube every 10 days):

If the number of tubes you use/used changed over time, describe and provide the dates or time periods of each such usage:

Q. The number of 1.4 oz tubes of Poligrip you use/used in *each* of the following time periods: [Answer each subpart separately]

1. one week:

2. one month:

3. 6 months:

4. 1 year:

5. Other (for example, one 1.4 oz. tube every 10 days)

If the number of tubes you use/used changed over time, describe and provide the dates or time periods of each such usage:

R. Briefly describe, separately as to your ***upper*** denture and ***lower*** denture, your typical application process of Poligrip to your dentures, including *but not limited to* (a) whether you use separate drops or a solid line of adhesive on each denture; (b) where on each denture you apply adhesive; (c) whether your typical application results in any ooze or overflow. (If your application process has changed over the years, separately describe each application process used and provide the dates or time periods of each such usage.)

XIII. Use of Fixodent

If you have used Fixodent denture adhesive cream at any time, please answer the following questions. If not, please leave blank.

A. Date of first use of Fixodent: 1992

B. Date of last use of Fixodent (if ongoing, please state): 09/2009

C. If you have discontinued your use of Fixodent, state the reason you stopped using Fixodent:

1. If you discontinued your use of Fixodent, were you advised to stop using Fixodent by a Health Care Provider or Oral Health Care Provider? Yes ✓ No_____

2. If you answered yes above, state the name of the Provider and the approximate date you were so advised: **Susan XXXX, M.D. - 09/15/2009**

D. Did you use Fixodent continuously during the time period described in (A) and (B) above? Yes ✓

E. If you did not use Fixodent continuously, state the dates or time periods you used Fixodent:

F. The type(s) of Fixodent you normally use or used (for example, Fixodent Complete, Fixodent Fresh, Fixodent Free, Fixodent Original, Fixodent Comfort, Fixodent Control, Fixodent Control + Scope Flavor, or other):

G. The tube size of Fixodent you normally purchase or purchased (for example, 1.4 oz., 2.0 oz., 2.2 oz., 2.4 oz., other):

H. If you have used more than one type of Fixodent, state the type and the approximate dates or time periods of use of each:

I. The number of times per week you use/used Fixodent (and, if different over time, describe and provide the dates or time periods of each such usage): **two tubes per week**

J. For your ***upper*** denture, the number of times per day you apply/applied Fixodent to your upper dentures (and, if different over time, describe and provide the dates or time periods of each such usage):

K. For your ***lower*** denture, the number of times per day you apply/applied Fixodent to your lower dentures (and, if different over time, describe and provide the dates or time periods of each such usage):

L. Did you or do you clean your dentures before each application of Fixodent? Yes No Sometimes ___

1. If you answered yes or sometimes, please describe your denture cleaning process:

M. Do you have other dental appliance(s) (for example, bridge, plate, mouth guard, crown) to which you applied/apply Fixodent? Yes__ No__

1. If yes, please identify the appliance(s) and the number of times per day that you use Fixodent with each appliance:

N. Every store or pharmacy where Fixodent was purchased by you or on your behalf and the dates of purchase:

O. Identify every Oral Health Care Provider from whom you received Fixodent:

P. The number of 2.4 oz tubes of Fixodent you use/used in *each* of the following time periods: [Answer each subpart separately]

1. one week: Two tubes
2. one month:
3. 6 months:
4. 1 year:
5. Other (for example, one 2.4 oz tube every 10 days):

If the number of tubes you use/used changed over time, describe and provide the dates or time periods of each such usage:

Q. The number of 1.4 oz tubes of Fixodent you use/used in *each* of the following time periods: [Answer each subpart separately]

1. one week:

2. one month:

3. 6 months:

4. 1 year:

5. Other (for example, one 1.4 oz tube every 10 days):

R. If the number of tubes you use/used changed over time, describe and provide the dates or time periods of each such usage:

S. Briefly describe, separately as to your ***upper*** denture and ***lower*** denture, your typical application process of Fixodent to your dentures, including *but not limited to* (a) whether you use separate drops or a solid line of adhesive on each denture; (b) where on each denture you apply adhesive; (c) whether your typical application results in any ooze or overflow. (If your application process has changed over the years, separately describe each application process used and provide the dates or time periods of each such usage.)

XIV. Request for Production of Documents Directed to Plaintiff(s)

Please produce the following non-privileged documents (including but not limited to emails and internet articles or postings) with this Fact Sheet, to the extent that such documents are currently in your possession or in the possession of your lawyers:

1. All documents you or anyone acting on your behalf reviewed in preparation of this Fact Sheet.

2. A copy of all medical records regarding the Denture Adhesive Cream User from any Health Care Provider who treated the Denture Adhesive Cream User for any disease, condition or symptom referred to in response to the questions above.

3. A copy of all dental records regarding the Denture Adhesive Cream User from any Oral Health Care Provider who has treated the Denture Adhesive Cream User for any reason, including for the care and fitting of dentures.

4. To the extent not included in the foregoing, all records relating to any examination of the Denture Adhesive Cream User by any Health Care Provider or Oral Health Care Provider, conducted for any purpose during the time period of 10 years preceding your first use of dentures to the present.

5. A copy of any and all purchase receipts showing proof of purchase of Poligrip or Fixodent by the Denture Adhesive Cream User or on his or her behalf.

6. If the Denture Adhesive Cream User has been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding.

7. Reports of all diagnostic tests, including but not limited to blood tests, peripheral blood smears, bone marrow smears or testing, electromyograms, nerve conduction studies, somatosensory evoked potential studies, visual evoked potential studies, brainstem auditory evoked potential studies, other neurological testing, X-rays, MRIs, CT scans, and other imaging studies administered to the Denture Adhesive Cream User at any time.

8. Copies of all documents in your possession from physicians, Health Care Providers, Oral Health Care Providers or others relating to the use of Denture Adhesive Cream, or to any condition you claim is related to the use of Denture Adhesive Cream, or recording or reflecting the use of any Denture Adhesive Cream by the Denture Adhesive Cream User.

9. All documents constituting, concerning, or relating to product use instructions, product warnings, package inserts or other materials obtained by the Denture Adhesive Cream User or his or her agents, representatives or anyone acting on the Denture Adhesive Cream User's behalf (other than your attorneys in this case) in connection with the use of any Denture Adhesive Cream, including but not limited to Poligrip and/or Fixodent. This request seeks documents already in your possession, or that come into your possession, that were and/or are obtained by you from any source *other than* the documents that Defendants either have or may produce during the course of discovery in this lawsuit.

10. All prescriptions, prescription records, drug containers and labels, informational brochures, advertisements, package inserts and other documents setting forth warnings and/or instructions relating to any medications, drugs, vitamins or supplements used by the Denture Adhesive Cream User as identified in Section VII of this Fact Sheet.

11. Any diaries, calendars, date books, or other documents which reflect use by the Denture Adhesive Cream User of any medications, drugs, vitamins or supplements and/or which record or reflect the occurrence, duration, or severity of any injury, illness, or disease affecting the Denture Adhesive Cream User within the time period of 10 years preceding your first use of dentures to the present.

12. Any releases, covenants not to sue, and any other agreement(s) between you and any other person relating in any way to the claims asserted in this lawsuit.

13. All press releases or other public statements made by or on behalf of you relating to this litigation (excluding postings on web sites of plaintiffs' attorneys).

14. All documents recording, reflecting or relating to any communication concerning Denture Adhesive Cream (including but not limited to Poligrip and/or Fixodent) that you or anyone acting on your behalf had with any governmental body, regulatory agency, trade group, pharmaceutical manufacturer or distributor, members of the press or news media, or other person (other than any communication with your lawyers in this case).

15. All documents recording, reflecting or relating to any communication that you or anyone acting on your behalf (including your attorneys) has had with any of the GSK Defendants and/or the P&G Defendants, including but not limited to any electronic or tape recording of any such communication(s).

16. All statements obtained from or given by any person having knowledge of facts relevant to the subject of this litigation.

17. All documents that relate to Denture Adhesive Creams (including but not limited to Poligrip and/or Fixodent), any alleged side effect of Denture Adhesive Cream, or the alleged injuries that are the subject of this lawsuit. This request seeks documents already in your possession, or that come into your possession, that were and/or are obtained by you from any source *other than* the documents that Defendants either have or may produce during the course of discovery in this lawsuit.

18. All documents relating to Denture Adhesive Creams or any alleged health risks or hazards related to Denture Adhesive Creams in your possession, or the possession of the Denture Adhesive Cream User, at or before the time of the injury alleged in your Complaint.

19. All documents you or anyone acting on your behalf (and not your lawyer) obtained directly or indirectly from any defendant.

20. All photographs, drawings, journals, slides or videos relating to the injuries alleged in your complaint (excluding materials prepared by Plaintiffs' experts, the production of which will be separate).

21. All documents that record, reflect or relate to any pecuniary loss or other damages, including all out of pocket expense documentation, that you claim resulted from the administration of any Denture Adhesive Cream as alleged in the Complaint.

22. If your complaint includes a claim of loss of support or loss of earnings or earning capacity, produce all W-2s (if you are an employee) and/or the federal income tax returns (if you are self-employed) of the Denture Adhesive Cream User since 1995 to the present.

23. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider.

24. Copies of letters testamentary, letters of administration or similar documentation relating to your status as plaintiff (if applicable).

25. Decedent's death certificate (if applicable).

26. Medical or coroner's reports regarding decedent's death (if applicable).

XV. Authorizations

Complete and sign the attached authorizations for release of records.

XVI. **Declaration**

I declare under penalty of perjury that all of the information provided in this Plaintiff's Fact Sheet is true and correct, that I have supplied all the documents requested in Section XIV of this Plaintiffs' Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied the authorizations attached to this declaration.

Signature Date

Printed Name