

Valsartan Questionnaire

Potential clients (injured person) name: _____

DOB: _____

Inquirer Name (if different): _____

Inquirer's relationship to injured person:

Mailing Address: _____

Physical Address (if different): _____

City/State/Zip: _____

Primary phone: _____

Secondary phone: _____

May we text you? If yes, who is your provider: _____

Email Address: _____

What is your preferred method of contact: _____

Injured Person spouse name: _____

(If Injured Person Is Deceased)

Date of Death: _____

State of Death: _____

State of Ingestion: _____

Cause(s) of Death: _____

Residency at time of Death: City & State: _____

Has an Estate been opened: _____

If yes, who has been appointed Personal Representative: _____

General Prescribing Questions

When did you start taking Valsartan or combination medication including valsartan?

Approx. (month/year): _____

When did you stop taking Valsartan or combination medication including valsartan?

Approx. (month/year): _____

What dosage of valsartan did you take, if you know? _____

Have you been diagnosed with any of the following cancers? (DECLINE if not dx or dx was prior to 2017)

Stomach cancer? _____

Month/year dx : _____ State dx: _____

Treatment received: _____

Small Intestine cancer? _____

Month/year dx : _____ State dx: _____

Treatment received: _____

Colorectal cancer? _____

Month/year dx : _____ State dx: _____

Treatment received: _____

Esophageal cancer? _____

Month/year dx : _____ State dx: _____

Treatment received: _____

Liver cancer? _____

Month/year dx : _____ State dx: _____

Treatment received: _____

Prostate cancer? _____ (DECLINE if over age 65 at time of dx)

Month/year dx : _____ State dx: _____

Treatment received: _____

Pancreatic cancer? _____

Month/year dx : _____ State dx: _____

Treatment received: _____

Leukemia? _____

Month/year dx : _____ State dx: _____

Treatment received: _____

Non-Hodgkins Lymphoma? _____

Month/year dx : _____ State dx: _____

Treatment received: _____

Multiple Myeloma cancer? _____

Month/year dx : _____ State dx: _____

Treatment received: _____

Other Cancer: _____

Month/year dx : _____ State dx: _____

Treatment received: _____

General Prescription and Ingestion History

Please list all pharmacies that filled your valsartan prescription, including the city and state?

Please list all states where you ingested the medication?

Who prescribed the valsartan and what state did you see this physician?

Confounding Factors

Explain your smoking history (including when you smoked, how much you smoked a day, and how long you smoked).

Does anyone in your family have a history of Cancer? (If yes, who and what type of cancer)

Do you have a history of liver injury or disease? (If yes, what was the injury (cirrhosis, Hepatitis B or C, fatty liver) and when were you diagnosed?

Recall notification, Pill Bottles and Pills

Have you received any notification that you received valsartan tainted with N-nitrosodimethylamine (NDMA)?

Do you currently have any of the pill bottles at home and/or are you aware of the manufacturer of your Valsartan?

If yes, are you able to confirm which company manufactured your valsartan?:

Has a physician indicated that your cancer may be related to your ingestion of valsartan? _____

If so, who? _____

Do you currently have any Valsartan pills in your possession?

If you do not have pills who did you give them to or where did you dispose of them?

What made you call our office today?

Have you contacted another attorney about this case? (if so, what was the result)

What is the best way to for us to communicate with you? (Phone, email, fed ex)

****** Please be sure to save all evidence of Valsartan, including any proof of purchase, receipts, packaging, boxes, etc. ******