

Redux YES NO

Date started: ____/____/____
month date year

Date stopped: ____/____/____
month date year

Pondimin YES NO

Date started: ____/____/____
month date year

Date stopped: ____/____/____
month date year

Are you still taking Permax/Dostinex? YES NO

Date started taking Permax/Dostinex: ____/____/____
month date year

Date stopped taking Permax/Dostinex: ____/____/____
month date year

What dose was originally prescribed? _____ Was the dose ever changed? YES NO

If YES, when was the dose changed? _____ New dose prescribed: _____

Pharmacy(ies) where Permax/Dostinex was purchased:

Name of Pharmacy Address City/State/ZIP (____) Telephone Number

Name of Pharmacy Address City/State/ZIP (____) Telephone Number

What warnings, if any, did the doctor or pharmacist give you, or the deceased patient, about Permax/Dostinex?

Please list all other medications, including prescription drugs, over-the-counter products, vitamins, herbal medications, and dietary supplements that you, or the deceased patient, used while taking Permax/Dostinex (please include dosages):

SYMPTOMS/TREATMENT INFORMATION:

What symptoms did you, or the deceased patient, experience while using Permax/Dostinex?

When did you start to experience these symptoms? _____

Did you report these symptoms to a doctor? YES NO
 If YES, please list doctor(s) or hospital(s) where you were treated for these symptoms:

Name of Doctor/Hospital	Address	City/State/ZIP
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Name of Doctor/Hospital	Address	City/State/ZIP
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Did you have heart valve damage while taking Permax/Dostinex? YES NO
 If YES, when: _____

Did you have primary pulmonary hypertension "PPH" while taking Permax/Dostinex? YES NO
 If YES, when: _____

Did you have pulmonary fibrosis while taking Permax/Dostinex? YES NO
 If YES, when: _____

Did the doctor/hospital tell you to stop taking Permax/Dostinex because of any of these problems? YES NO

Were you admitted to the hospital **for these symptoms**? YES NO
 If YES, when were you hospitalized: _____ (month/year)
 If YES, how long were you hospitalized: _____ days
 If YES, where were you hospitalized?

Name of Hospital	Address	City/State/ZIP
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Name of Hospital	Address	City/State/ZIP
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TREATMENT:

Did you have a Heart Valve Surgery performed for your injury/injuries indicate above? YES NO
 If YES, when: _____

If YES, please list doctor(s) or hospital(s) where you had this surgery performed:

Name of Doctor/Hospital	Address	City/State/ZIP
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Were you prescribed "Bosanten" or "Tracleer" for pulmonary issues? YES NO
 (Please only answer this question if you developed pulmonary issues while taking Permax/Dostinex)
 If YES, when: _____

If YES, please list doctor(s) or hospital(s) where you had this surgery performed:

Name of Doctor/Hospital	Address	City/State/ZIP
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CARDIOVASCULAR DIAGNOSTIC TESTS:

Please indicate which test you had performed below for your injury/injuries indicated above:

Echocardiogram (Not an EKG but an Echo)	YES	NO
If YES, when: _____		
Heart Catheterization	YES	NO
If YES, when: _____		
Angiogram	YES	NO
If YES, when: _____		
Pulmonary Function Test	YES	NO
If YES, when: _____		
Perfusion Lung Scan	YES	NO
If YES, when: _____		

MEDICAL HISTORY INFORMATION:

Were you, or the deceased patient, diagnosed with any of the following conditions, if so **please circle the specific condition:**

Parkinson's Disease	YES	NO
Restless Leg Syndrome	YES	NO
Hyperlactemia	YES	NO
Rheumatic Heart Disease	YES	NO
Cardiac Disease	YES	NO
Endocarditis	YES	NO
Do you drink alcohol?	YES	NO
If YES, how much per day: _____		
Do you smoke?	YES	NO
If YES, how much per day: _____		
Do you or have you used any illicit/street drugs?	YES	NO
If YES, please list: _____		

Which of these conditions/diseases were you diagnosed with **prior to starting Permax/Dostinex:**

Which of these conditions/diseases were you diagnosed with **after starting Permax/Dostinex**:

Family medical history: _____

Please answer the Following for Future Use:

Marital Status: Single Married Divorced Widowed

Employment Status: Full-time Part-time Disabled Retired

Employer: _____

Do you have Health Insurance? _____

Did health insurance pay for any hospitalization related to Permax/Dostinex usage? Yes
No

Insurance Provider Name: _____

Have you ever filed Bankruptcy? _____ Date of Bankruptcy: _____

Type of Bankruptcy filed: _____

Date of Discharge: _____ Is Bankruptcy Pending? _____

Who is your Bankruptcy Attorney? _____

Address and Phone Number: _____

Do you receive Social Security benefits? Yes No _____

Do you receive Medicaid benefits? Yes No _____

Do you receive Medicare benefits? Yes No _____

Do you receive any type of public assistance? Yes No _____

Do you receive VA benefits? Yes No _____