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FOSAMAX CLASS ACTION

Claimant information

Please answer each question below as accurately as possible and provide as much information as you need to.

Feel free to attach additional papers if you need to.

Section 1: Personal Information of Claimant

1. Name

2. Address

3. Gender MALE FEMALE
4. Driver's license Number

5. State of Driver's License Issuance

6. Date of Birth
___ / ___ / _____
7. Place of Birth

8. Are you completing this form on behalf of somebody else? YES NO
9. If you answered YES to question 8, please complete the following

a)Name

b)Address

c)Gender MALE FEMALE

d)Driver's licence Number

e)State of Driver's Licence Issuance

f) Date of Birth

___ / ___ / _____

g)Place of Birth

Section 2: Prescription of Fosamax

1. Were you prescribed Fosamax (or another type of Bisphosphonate) tablets by your doctor?

YES NO

2. **If you answered NO to Question 1**, please provide details of how you obtained Fosamax tablets (e.g. I was given free samples by my doctor, I took my husband's tablets, etc.):

3. Please identify which of the following medications you have taken:

Brand Name	Yes	No	Unknown
Alendrobell			

Brand Name	Yes	No	Unknown
Alendro 10			
Alendro 40			
Alendro Once-Weekly			
Apo-Alendronate			
GenRx Alendronate			
ChemMart Alendronate			
Fosamax			
Fosamax Once Weekly			
Ossmax			
Terry White Chemists Alendronate			
Fosamax Plus Once Weekly			
Didronel			
Didrocal			
Pamisol			
Aredia			
Disodium Pamidronate Hexal			
Bondronat			
Bonviva Once Monthly			
Bonviva Quarterly Injection			
Actonel Once-a-Week			
Actonel			
Actonel Combi			
Bonefos			
Skelid			
Zometa			
Other_____			

4. Please provide details of the period over which you were prescribed the Fosamax or bisphosphonate. If you are in any doubt about this, please check these details with your doctor or pharmacy (e.g. May 1996 – June 2001, or May 2001 – June 2002 and then October 2003 – September 2007):

5. Did you purchase the Fosamax or bisphosphonate tablets that you were prescribed?

YES NO

6. **If you answered NO to Question 5**, please provide details of the person or people who purchased the Fosamax or bisphosphonate tablets that you consumed (e.g. my husband, my daughter, my carer, etc.):

7. Please provide the names and addresses of the pharmacies where your Fosamax or bisphosphonate tablets were purchased:

Section 3: Fosamax consumption history

1. Did you take your Fosamax or bisphosphonate tablets every day?
If YES, go to QUESTION 3

YES NO

2. **If you answered NO to Question 1**, please provide details of how often you took your Fosamax or bisphosphonate tablets (e.g. 'Daily', or 'I took one tablet every day for three weeks, and then again three months later when my back pain returned for a further three weeks every day', or 'I took them most days but occasionally forgot'):

3. Please describe the dates between which you **consumed** Fosamax or bisphosphonate tablets (it is important that these dates be as accurate as possible):

Section 4: Injury suffered

1. Please indicate whether you suffered any of the following conditions after using Fosamax or bisphosphonate, and if so, when they occurred:

Osteonecrosis of the Jaw: YES NO

Osteomyelitis of the Jaw: YES NO

Increased Risk of Developing Osteonecrosis of the Jaw: YES NO

Other (Please Specify): YES NO

2. When do you claim this injury first occurred? _____

3. Date of medical diagnosis: _____

- a) Name, address, telephone number and specialty of the person who diagnosed this injury:

- b) Name, address, telephone number and specialty of the person who treated this injury:

4. Was the condition identified in Question 1 suffered following dental treatment?

YES NO

5. If possible, please describe what happened to you when you suffered the above injury or injuries (feel free to attach additional papers if needed):

f) Name, address, telephone number and specialty of the person who treated this injury:

8. Have you had discussions with any physician(s), dentist(s), or other health care provider(s) about whether any injury described in Section 4 is related to the use of Fosamax or bisphosphonate?

YES NO

a) **If YES**, Please identify:

i. Name(s) of health care provider(s):

ii. Address(es):

iii. Specialty:

iv. Date(s) of Discussion(s):

b) Do you recall what you were told? YES NO

c) **If YES**, what were you told?

[If discussed with more than one health care provider, please outline which health care provider the discussion was with, and the conversation had with each of them]

9. At any time before, during or after your Fosamax or bisphosphonate treatment, did you have a conversation with any physician, dentist or other health care provider about whether Fosamax therapy or any other bisphosphonate use put you at an increased risk of harm?

YES NO

a) **If YES**, Please identify:

- i. Name(s) of health care provider(s):

- ii. Address(es):

- iii. Specialty:

- iv. Date(s) of Discussion(s):

b) Do you recall what you were told? YES NO

3. To the best of your knowledge, did you use or take any of the following medications or treatments *before* the injury that you allege you suffered occurred? **If YES**, please provide in the below table, the first and last date on which you took the medication or treatment.

	Yes	No	Date First Taken	Date Last Taken
Corticosteroids or other steroids				
Radiation therapy				
a. Head and/or Neck				
b. Other Body Part				
Chemotherapy				
Hormonal therapy (including, but not limited to, estrogen therapy, oral contraceptive, estrogen/progestin therapy, anti-estrogens, aromatase inhibitors, and anti-androgens/androgen deprivation therapy)				
Blood pressure (hypertension) medication				
Cholesterol-lowering medication				
Medication for the treatment of Rheumatoid Arthritis				
Medication for the treatment of Diabetes				

4. Have you participated in any clinical trials or taken any experimental drugs?

YES NO

If "yes," please indicate when you participated in such trials, where the trials took place, which drugs you took, and for what condition you took such drugs.

5. Have you had any of the following dental work undertaken at any time?

	Yes	No	Unknown
Gingivectomy or gum resection			
Periodontal surgery			
Oral surgery			
Root canal or other endodontic procedure			
Root planing, scaling, or other treatment for gum disease			
Any invasive dental procedure			
Ridge smoothing			
Debridement of the oral cavity			
Bone trimming			
Apicoectomy			
Bone jaw biopsy			
Dental x-rays, panorex, or other dental imaging			
Other diagnostic test or imaging of the mouth or jaw Please specify: _____			