

**UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA**

IN RE: RENU WITH MOISTURELOC
LIABILITY LITIGATION

) Case No. 2:06-mn-77777
) (MDL Docket No. 1785)
)
)

THIS DOCUMENT RELATES TO:

) JUDGE NORTON
)
)

[PLAINTIFF]

v. BAUSCH & LOMB, INC.

)

PERSONAL INJURY PLAINTIFF FACT SHEET

Please provide the following information for each individual on whose behalf a claim is being made. If you are completing this Plaintiff Fact Sheet in a representative capacity, please respond to the remaining questions with respect to the person who used ReNu® with MoistureLoc®. Whether you are completing this fact sheet for yourself or for someone else, please assume that “You” means the ReNu® with MoistureLoc® user. In filling out this form, please use the following definitions: “healthcare provider” means any hospital, clinic, center, physician’s office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, and any pharmacy, x-ray department, or entities involved in the diagnosis, care and/or treatment of you. Each plaintiff shall respond to this Fact Sheet as though it were standard discovery, providing responses in accordance with Fed. R. Civ. P. 33.

If additional space is needed for any response, please attach additional sheets as necessary. If the person completing this Fact Sheet does not know or does not recall the information requested in any question(s), that response should be entered in the appropriate location(s).

Name of plaintiff: _____

Name of person completing this form: _____

I. CASE INFORMATION

A. Please state the name, address, telephone number, fax number, and email address of the principal attorney representing you:

Name

Firm

City, State and Zip Code

Telephone number

Fax number

Email address

B. If you are completing this Fact Sheet in a representative capacity (e.g., on behalf of the estate of a deceased person), please complete the following:

1. _____
Your Full Name

2. _____
Street Address

3. _____
City, State and Zip Code

4. In what capacity are you representing the individual?

5. Your relationship to the represented person:

II. PERSONAL INFORMATION

A. Please state your full name, sex, social security number, and date and place of birth:

Last Name First Name Middle Initial Sr./Jr.

Sex: Male ___ Female ___

Social Security Number: _____

Date of Birth: _____
mm/dd/yyyy

Place of Birth: _____

B. Maiden or other names used by you or by which you have been known and dates when used:

C. Present Street Address: _____

City

State

Zip Code

D. Are you currently married? Yes ____ No ____

If "Yes," spouse's name: _____

Is your current spouse making a loss of consortium claim?

Yes ____ No ____

If a former spouse is making a loss of consortium claim, state his or her name and address:

E. To your knowledge, has anyone in your immediate family or household been diagnosed with or suffered from any eye infection since January 1, 2001?

Yes ____ No ____ Do Not Know _____

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

1. Name: _____

2. Relation to You: _____

3. Description of Medical Condition: _____

4. Age at Onset of Condition: _____

5. Current Age (or Age at Death): _____

III. CLAIM-RELATED INFORMATION

A. Are you claiming that you have suffered bodily injury as a result of exposure to ReNu® with MoistureLoc®?

Yes ____ No ____

B. Are you claiming mental and/or emotional damages as a result of exposure to ReNu® with MoistureLoc®?

Yes ____ No ____

C. Claim Information

1. When did you wear contact lenses:

From _____ (Month/Year) to _____(Month/Year).

2. How frequently did you wear contact lenses during this time?

3. State the type and brand of contact lenses you used at the time of your alleged injury. (e.g., daily wear):

4. When did you use ReNu® with MoistureLoc®?

From _____ (Month/Year) to _____(Month/Year).

5. In the last 5 years, has any optometrist, ophthalmologist, or other eye care professional advised you to discontinue contact lens use?

Yes ____ No ____

6. If “Yes” to III.C.5, identify the eye care professional who so advised you, and the date of the advice:

7. Identify each disease, illness, medical injury, or any other type of injury that you claim to have suffered as a result of your alleged use of ReNu® with MoistureLoc®:

8. State the date of onset of the symptoms of any disease, illness, or injury identified in your response to question III.C.7 above:

9. Are you making a claim for medical expenses as a result of the alleged injury identified in question III.C.7? "Medical Expenses" includes, but is not limited to, all charges for care, treatment or diagnosis by a medical professional; hospital costs, charges and expenses; and all medication expenses.

Yes ____ No ____ If Yes, state in what amount:

10. Do you have health insurance? Yes ____ No ____

If Yes, Insurer _____ Policy # _____

If "No" to question III.C.10 above, are you covered by Medicare?

Yes ____ No ____

11. Are you making a claim for out-of-pocket expenses?

Yes ____ No ____

If Yes, state in what amount: _____

12. Are you making a claim for lost earnings or have you suffered an impairment of your ability to earn as a result of any condition which you believe was caused by your exposure to ReNu® with MoistureLoc®?

Yes ____ No ____

13. If "Yes," state the total amount of time which you have lost from work as a result of any and all condition(s) which you claim was caused by your exposure to ReNu® with MoistureLoc® and your understanding of the amount of income that you lost:

-
-
14. If you are making a claim for lost earnings and/or lost earning capacity, state your income from employment for each of the last five (5) years:

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

15. If you are making a claim for lost earnings and/or lost earning capacity, state whether you are currently employed? Yes ____ No ____

If you are making a claim for lost earnings and/or lost earning capacity, please provide the following information for each and every employer you have had for the past ten (10) years:

Employer	Address	Dates of Employment	Job Description

16. If not employed, check all that apply and provide applicable dates:

- a) Unemployed: (seeking work) Yes ____ No ____ Date _____
- b) Unemployed: (not seeking work) Yes ____ No ____ Date _____
- c) Retired Yes _____ No ____ Date _____

17. If you are currently disabled, please state the cause of your disability and the period of your disability

IV. CONTACT LENS SOLUTION

- A. During the time period when you used ReNu® with MoistureLoc®, did you use any other contact lens cleaning solution?

Yes ____ No ____

1. If yes, what other contact lens cleaning solution(s) did you use?

2. If yes, when did you use other contact lens cleaning solution(s)?

- B. Please provide the information below for any contact lens cleaning solution product that you have used other than ReNu® with MoistureLoc® since January 1, 2001.

Non- ReNu® with MoistureLoc® Product	Period(s) of Use

- C. During the time period when you used ReNu® with MoistureLoc®, where did you purchase or obtain the product?

1. What lot numbers are on the ReNu® with MoistureLoc® bottle that you used at the time you claim to have been injured?

2. What size bottle of ReNu® with MoistureLoc® were you using at the time you claim to have been injured?

3. During the time period when you used ReNu® with MoistureLoc®, identify the name and address of the person/business that provided your contact lenses?

D. In last five (5) years, have you used artificial tears, eye drops or eye lubricants? If yes, please identify the product(s) and when the product(s) was used?

V. MEDICAL DIAGNOSIS

A. Please identify the diagnosing and treating medical professional(s) for each disease, illness or injury that you claim you suffered as a result of your alleged exposure to ReNu® with MoistureLoc® and the date of the diagnosis. Please provide a medical record authorization for each medical professional identified.

Name: _____
 Specialty, if any: _____
 Address: _____
 Phone: _____
 Treatment received: _____
 Dates of treatment: _____

Name: _____
 Specialty, if any: _____
 Address: _____
 Phone: _____
 Treatment received: _____
 Dates of treatment: _____

Name: _____

Specialty, if any: _____

Address: _____

Phone: _____

Treatment received: _____

Dates of treatment: _____

- B. Describe any physical symptoms, psychological symptoms or emotional problems that you allege to have experienced in connection with each disease, illness, or other medical injury you are seeking relief for in this case:

If you are alleging psychological symptoms or emotional problems, please identify any physician that you have received psychological care and provide a medical records authorization.

- C. Has any eye care professional told you that your injury was related to ReNu® with MoistureLoc®? If yes, please provide the name and address of the eye care professional.

- D. Have you had a corneal scraping? If yes, please identify the date of the procedure, the physician who performed the procedure and provide the results of any culture.

- E. Have you had a corneal transplant? If yes, please identify the date of the procedure, the physician who performed the procedure and where the procedure was performed.

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- F. Has any eye care professional recommended that you have a corneal transplant? If yes, please identify the eye care professional(s) making such a recommendation.
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-

- G. What is your current best corrected visual acuity? (i.e. 20/20, 20/40, 20/80)
-

- H. What was your best corrected visual acuity at the time you started using MoistureLoc®? (i.e. 20/20, 20/40, 20/80)
-

- I. Are there persons (other than those already identified in this Fact Sheet) whom you believe are witnesses to your claimed injuries or damages? If yes, please provide their name(s) and address(es):

1. _____
2. _____
3. _____
4. _____
5. _____

VI. MEDICAL HISTORY

- A. Has any medical professional ever diagnosed you with any of the following:

Check yes or no; if "Yes" provide the date of diagnosis and medical professional or hospital information.

Disorder or Disease	Yes	No	Date(s) Diagnosed	Name and address of medical professional(s) and/or hospital(s) who diagnosed you
Conjunctivitis				
Fungal Keratitis				
Microbial Keratitis				
Bacterial Keratitis				

Glaucoma				
Cataracts				
Corneal Ulcer				
Thygeson's Superficial Punctate Kertopathy				
Fuchs' Dystrophy				
Uveitis				
Retinal Detachment				
Retinoschisis				
Hypertensive Retinopathy				
Macular Degeneration				
Retinitis Pigmentosa				
Macular Edema				
Leber's Hereditary Optic Neuropathy				
Keratomycosis				
Ocular Surface Disease				
Immune System Disorder Including HIV¹				
Herpes Simplex Keratitis				

- B. Have you ever been prescribed an immunosuppressant drug? (Immunosuppressant drugs include but are not limited to steroids, cyclosporine, and methotrexate)

Yes _____ No _____

If "Yes," please identify the drug and dates of use:

- C. Other than those individuals that you have identified above, please identify the name and address of any medical professional you have seen for eye care for any reason including but not limited to any ophthalmologist, optometrist, contact lens fitter, and/or primary care physician. Please provide a medical record authorization for each medical professional identified.

Name: _____
 Specialty, if any: _____
 Address: _____
 Phone: _____
 Reason for visit: _____

Name: _____
 Specialty, if any: _____
 Address: _____
 Phone: _____
 Reason for visit: _____

Name: _____
 Specialty, if any: _____
 Address: _____
 Phone: _____
 Reason for visit: _____

Name: _____
 Specialty, if any: _____
 Address: _____
 Phone: _____
 Reason for visit: _____

Name: _____
 Specialty, if any: _____
 Address: _____
 Phone: _____
 Reason for visit: _____

- D. Identify the name and address of any other medical professional that has treated you since January 1, 1996. Please provide a medical record authorization for each medical professional identified.

Name: _____
 Specialty, if any: _____
 Address: _____
 Phone: _____

¹ All information provided in this Fact Sheet with respect to HIV and herpes simplex keratitis is covered by the Confidentiality Order issued by the Court.

Reason for visit: _____

Name: _____

Specialty, if any: _____

Address: _____

Phone: _____

Reason for visit: _____

Name: _____

Specialty, if any: _____

Address: _____

Phone: _____

Reason for visit: _____

Name: _____

Specialty, if any: _____

Address: _____

Phone: _____

Reason for visit: _____

Name: _____

Specialty, if any: _____

Address: _____

Phone: _____

Reason for visit: _____

Name: _____

Specialty, if any: _____

Address: _____

Phone: _____

Reason for visit: _____

Name: _____

Specialty, if any: _____

Address: _____

Phone: _____

Reason for visit: _____

- E. Please provide the following information for each hospitalization that you have had during the last ten (10) years. Please provide a medical record authorization for each hospital identified. If you cannot remember all of the details, please list as much information as you can.

Name of hospital: _____

Address: _____

Phone: _____

Reason for hospitalization: _____

Name of hospital: _____

Address: _____

Phone: _____

Reason for hospitalization: _____

Name of hospital: _____

Address: _____

Phone: _____

Reason for hospitalization: _____

Name of hospital: _____

Address: _____

Phone: _____

Reason for hospitalization: _____

VII. PRIOR CLAIMS

A. Have you ever been convicted of, or pled guilty to, a felony and/or crime of fraud or dishonesty in the last ten (10) years?

Yes ____ No ____

B. If "Yes" to VII.A, please identify the felony and the date of such conviction or plea.

C. Have you ever, at any time, filed a lawsuit or made a claim, other than in the present lawsuit, relating to your eyes or vision? Or have you filed a lawsuit or made a claim, other than in the present lawsuit, relating to any bodily injury, disease, illness, or other medical condition since January 1, 1996?

Yes ____ No ____

If "Yes" to either question in VII.C, please state:

1. The claims you made:

2. The name of the court in which each action was filed:

3. The docket or civil action number assigned to each such claim, action or suit:

4. The date on which the claim was filed:

5. The name and address of each medical professional who examined, treated, counseled or otherwise assisted you in connection with the claim:

6. The disposition of the claim, including the amount, date, and frequency of any award (if amount is per week, month, year, or other unit of time, provide duration, *e.g.* \$1,000/month for 24 months):

7. Did you testify either at trial or at a deposition? Yes _____ No _____

D. Have you ever filed a worker’s compensation claim relating to your eyes or vision? Or have you filed a worker’s compensation claim relating to any other bodily injury, disease, or illness since January 1, 1996?

Yes _____ No _____

If “Yes” to either question in VII.D, please provide the following for each claim:

1. Are you currently receiving worker’s compensation benefits?

Yes _____ No _____

2. Date claim was filed:

3. Name and address of the office where the claim was filed:

4. Claim/docket number, if applicable:

5. Nature of disability claimed:

6. Period of disability (please provide beginning and ending date – if ongoing or permanent, so state):

7. Disposition of the claim, including the date, amount, and frequency of any award (if amount is per week, month, year, or other unit of time, provide duration, *e.g.* \$1,000/month for 24 months):

8. Name and address of each medical professional who examined, treated, counseled or otherwise assisted you in connection with the claim:

- E. Have you ever filed a disability claim with the Social Security Administration or the Department of Veterans Affairs relating to your eyes or vision? Or have you filed a disability claim with the Social Security Administration or the Department of Veterans Affairs relating to any other medical issue since January 1, 1996?

Yes ____ No ____

If "Yes" to either question in VII.E, please provide the following for each claim:

1. Are you currently receiving Social Security of VA benefits?

Yes ____ No ____

2. Date claim was filed:

3. Name and address of the office where the claim was filed:

4. Claim/file number:

5. Nature of disability claimed:

6. Period of disability (please provide beginning and ending date – if ongoing or permanent, so state):

7. Disposition of the claim, including the amount, date and frequency of any award (if amount is per week, month, year, or other unit of time, provide duration, *e.g.* \$1,000/month for 24 months):

- 8. Name and address of each medical professional who examined you in connection with the claim:

[Attach additional sheets if necessary to describe more than one claim in any of the above categories]

VIII. INSTRUCTIONS FOR CONTACT LENS CARE AND USAGE

- A. Were you ever given any written instructions or warnings regarding contact lens care and usage?

Yes ____ No ____ Do not recall ____

- 1. If "Yes," please attach a copy of the written instructions or warnings.
- 2. If "Yes," please identify the name and address of the person or business providing such written instructions or warnings.

- B. Were you ever given any oral instructions or warnings regarding contact lens care and usage?

Yes ____ No ____ Do not recall ____

- 1. If "Yes," please identify the person or health care provider providing such information.

IX. DOCUMENTS²

Please provide a copy of all of your documents and things which fall into the categories listed below. This includes documents and things in your personal possession, as well as items being held for you by another person, including your lawyer or any relative.

1. A copy of all medical records from any physician, hospital, clinic, healthcare provider or pharmacy that treated you or provided medications for eye related disorders.
2. If you have been the claimant or subject of any worker's compensation, Social Security or other disability proceeding during the time periods described in Section VII, all documents related to such proceeding.
3. All instructions, packaging, advertising materials, pamphlets, magazine or newspaper articles, internet information, promotional materials, and any other documents that you have regarding ReNu® with MoistureLoc®.
4. All instructions or other information regarding contact lens care.
5. The entire packaging, including the bottle and box, for the ReNu® with MoistureLoc® that you allege caused your injury and any remaining solution.
6. The lens case that you were using at the time that you allege injury from ReNu® with MoistureLoc®.
7. The contact lenses that you were using at the time you allege injury from ReNu® with MoistureLoc®.
8. Any receipts or other documents that reflect your purchase of ReNu® with MoistureLoc®.

² Items disclosed in this Fact Sheet pursuant to requests 5, 6 and 7 of section IX shall be available for inspection and testing pursuant to a protocol to be agreed upon by the parties or ordered by the Court.

9. If you are claiming lost wages or a loss of earning capacity, your federal tax returns for each of the last five (5) years and any other documents evidencing your lost wages or loss of earning capacity.

10. If you claim any loss from medical expenses, copies of all bills or documentation of expenses for which you are seeking reimbursement from any physician, hospital, pharmacy or other health care provider.

11. Copies of letters testamentary or letters of administration relating to your status as plaintiff.

X. AUTHORIZATIONS

Complete and sign the attached authorizations for Release of Medical Records for the medical providers and hospitals identified in this fact sheet.

Complete and sign the attached authorizations for Release of Employment and Unemployment Records for the employer(s) identified in this fact sheet for whom you were working since January 1, 2001.

If you have filed a Worker's Compensation or Social Security disability claim during the time period described in VII, please complete and sign the attached Authorization for Release of Worker's Compensation and Social Security Records.

Complete and sign the attached authorization for the release of insurance records relating to your medical treatment for the last ten (10) years.

DECLARATION

I, _____, declare under penalty of perjury that all of the information provided in this Fact Sheet is true and correct to the best of my knowledge, information, and belief. I understand and am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Signature: _____