



HAWKINS & WALKER

— ATTORNEYS AND COUNSELORS AT LAW —

CONFIDENTIAL CLIENT QUESTIONNAIRE ZANTAC (RANITIDINE)

*The information contained in this document is subject to the
Attorney-Client & Attorney-Work Product Privileges and is confidential*

CLIENT INFORMATION

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Birthdate: _____ SSN: _____

Primary Email: _____

Alternate Email: _____

Telephone: _____
Cell Work Home

Marital Status: _____ Spouse's Name: _____

If we cannot reach you, please provide the name and phone number of an emergency contact person we can leave a message with: _____

If you are completing this form for someone other than yourself, please give your name, relationship, address, and phone number:

Name: _____ Relationship: _____

Address: _____

Telephone: _____
Cell Work Home

If the Zantac recipient for whom you are answering these questions is deceased, what was his or her date of death? _____

* If deceased, please provide a copy of the death certificate with this questionnaire.

Are you currently represented by another law firm for a claim regarding this medication? _____

YOUR INJURY

A. When did you start taking Zantac? _____

B. When did you stop taking Zantac? _____

C. Frequency (Daily/Weekly/Monthly): _____

D. What type of Zantac did you take (Brand or Generic Ranitidine)? _____

E. Mg dose taken (75, 150, 300): _____

F. What type of cancer were you diagnosed with?

(Mark all that apply)

A. Type of Cancer: _____

Date of Diagnosis: _____

B. Type of Cancer: _____

Date of Diagnosis: _____

C. Type of Cancer: _____

Date of Diagnosis: _____

D. Type of Cancer: _____

Date of Diagnosis: _____

E. Type of Cancer: _____

Date of Diagnosis: _____

F. Type of Cancer: _____

Date of Diagnosis: _____

G. Approximate date of your Zantac injury (diagnosis): _____

H. Describe any other complications you have experienced related to your use of Zantac:

I. Please provide the approximate date when the symptoms or complications from Zantac began:

J. Have you suffered any emotional injury as a result of your Zantac injury? _____

If you answered yes, please describe:

K. Did you lose time off from work as a result of your injury? _____

If you answered YES, How long and when: _____

L. Are you still taking Zantac? _____

If you answered yes, please state the reason why you are still taking Zantac:

MEDICAL HISTORY

A. Family history of cancer? _____

a. If yes, what type of cancer? _____

Relation to client _____

b. If yes, what type of cancer? _____

Relation to client _____

c. If yes, what type of cancer? _____

Relation to client _____

B. Smoking history? _____

a. If yes, how many packs per day? _____

C. Alcohol consumption? _____

a. If yes, how many drinks per day/week? _____

D. Adolescent ingestion? _____

PHYSICIAN/TREATER INFORMATION:

Please provide the name, address and telephone number with area code of the doctor who told you your injury was caused by Zantac, and the name, address and telephone number with area code of the hospital where your Zantac injury was treated:

Family Doctor: _____
Address: _____

Phone: _____

Oncologist: _____
Address: _____

Phone: _____

Oncologist: _____
Address: _____

Phone: _____

Treating Doctor: _____
Address: _____

Phone: _____

Treating Doctor: _____
Address: _____

Phone: _____

Hospital: _____
Address: _____

Phone: _____

Hospital: _____
Address: _____

Phone: _____

Hospital: _____
Address: _____

Phone: _____

MEDICATIONS:

A. Do you have any empty or partially empty Zantac bottles? _____

* If you answered YES, please do not discard.

B. Please list the medications you are currently taking:

	Name of Drug	Dosage	Dates Taken	Reason Taken
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____
9.	_____	_____	_____	_____
10.	_____	_____	_____	_____
11.	_____	_____	_____	_____

* Please add additional sheet or write on the back of this page if additional space is needed.

C. Do you a copy of the receipts showing you purchased Zantac? _____

* If you answered YES, please do not discard.

WITNESSES

Please list two (2) good, credible witnesses who helped you through this difficult time in your life that we could call to testify on your behalf if needed.

Name: _____
Address: _____

Phone: _____
Relationship: _____

Name: _____
Address: _____

Phone: _____
Relationship: _____