IN RE: VIOXX® PRODUCTS LIABILITY LITIGATION	MDL Docket No. 1657
THIS RELATES TO: Civil Action No:	Plaintiff: _____ (name)

PLAINTIFF PROFILE FORM

Other than in Sections I, those questions using the term "You" should refer to the person who used VIOXX®. Please attach as many sheets of paper as necessary to fully answer these questions.

I.CASE INFORMATION

A. Name of person completing this form: _____

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

1. Social Security Number:_____
2. Maiden Or Other Names Used or By Which You Have Been Known:_____
3. Address:_____
4. State which individual or estate you are representing, and in what capacity you are representing the individual or estate? _____
5. If you were appointed as a representative by a court, state the:

   Court: _____ Date of Appointment: _____
6. What is your relationship to deceased or represented person or person claimed to be injured?_____
7. If you represent a decedent's estate, state the date of death of the decedent and the address of the place where the decedent died: _____

C. Claim Information

1. Are you claiming that you have or may develop bodily injury as a result of taking VIOXX®? Yes_____ No_____ ***If "yes,"***

   a. What is your understanding of the bodily injury you claim resulted from your use of VIOXX®? _____

   _____

   b. When do you claim this injury occurred?_____

   c. Who diagnosed the condition? _____

   d. Did you ever suffer this type of injury prior to the date set forth in answer to the prior question? Yes _____ No _____ ***If "yes,"*** when and who diagnosed the condition at that time? _____

   _____

   _____

   e. Do you claim that that your use of VIOXX® worsened a condition that you already had or had in the past? Yes ____ No _____ ***If "yes,"*** set forth the injury or condition; whether or not you had already recovered from that injury or condition before you took VIOXX®; and the date of recovery, if any. _____

   _____

D. Are you claiming mental and/or emotional damages as a consequence of VIOXX®? Yes ____ No ____

If "yes," for each provider (including but not limited to primary care physician, psychiatrist, psychologist, counselor) from whom have sought treatment for psychological, psychiatric or emotional problems during the last ten (10) years, state:

   a. Name and address of each person who treated you: _____

   _____

   b. To your understanding, condition for which treated: _____

   _____

   c. When treated: _____

   d. Medications prescribed or recommended by provider: _____

II. PERSONAL INFORMATION OF THE PERSON WHO USED VIOXX®

A. Name: _____

B. Maiden or other names used or by which you have been known: _____

C. Social Security Number: _____

D. Address: _____

E. Identify each address at which you have resided during the last ten (10) years, and list when you started and stopped living at each one:

Address	Dates of Residence

F. Driver's License Number and State Issuing License: _____

G. Date of Place and Birth: _____

H. Sex: Male ____ Female ____

I. Identify the highest level of education (high school, college, university or other educational institution) you have attended (even if not completed), the dates of attendance, courses of study pursued, and diplomas or degrees awarded:

Institution	Dates Attended	Course of Study	Diplomas or Degrees

J. Employment Information.

1. Current employer (if not currently employed, last employer):

Name	Address	Dates of Employment	Occupation/Job Duties

2. List the following for each employer you have had in the last ten (10) years:

Name	Address	Dates of Employment	Occupation/Job Duties

3. Are you making a wage loss claim for either your present or previous employment? Yes ____ No ____

If "yes," state your annual income at the time of the injury alleged in Section I(C):_____

K. Military Service Information: Have you ever served in the military, including the military reserve or national guard? Yes ____ No ____

If "yes," were you ever rejected or discharged from military service for any reason relating to your physical, psychiatric or emotional condition? Yes ____ No ____

L. Insurance / Claim Information:

1. Have you ever filed a worker's compensation and/or social security disability (SSI or SSD) claim? Yes ____ No ____ ***If "yes,"*** to the best of your knowledge please state:

   a. Year claim was filed: _____

   b. Nature of disability: _____

   c. Approximate period of disability: _____

2. Have you ever been out of work for more than thirty (30) days for reasons related to your health (other than pregnancy)? Yes ____ No ____ ***If "yes,"*** set forth when and the reason. _____
   _____
   _____

3. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury? Yes ____ No ____ ***If "yes,"*** state to the best of your knowledge the court in which such action was filed, case name and/or names of adverse parties, and a brief description for the claims asserted._____
   _____
   _____

M. As an adult, have you been convicted of, or plead guilty to, a felony and/or crime of fraud or dishonesty? Yes ____ No ____ ***If "yes,"*** set forth where, when and the felony and/or crime. _____

III.FAMILY INFORMATION

A. List for each marriage the name of your spouse; spouse's date of birth (for your current spouse only); spouse's occupation; date of marriage; date the marriage ended, if applicable; and how the marriage ended (e.g., divorce, annulment, death): _____

B. Has your spouse filed a loss of consortium claim in this action? Yes ____ No ____

C. To the best of your knowledge did any child, parent, sibling, or grandparent of yours suffer from any type of cardiovascular disease including but not limited to: heart attack, abnormal rhythm, arteriosclerosis (hardening or the arteries), murmur, coronary artery disease, congestive heart failure, enlarged heart, leaking valves or prolapse, heart block, congenital heart abnormality, Scarlet Fever, Rheumatic Fever, atrial fibrillation, stroke?
Yes ____ No ____ Don't Know _____ ***If "yes,"*** identify each such person below and provide the information requested.

Name: _____

Current Age (or Age at Death): _____

Type of Problem: _____

If Applicable, Cause of Death: _____

D. If applicable, for each of your children, list his/her name, age and address: _____

E. If you are claiming the wrongful death of a family member, list any and all heirs of the decedent. _____

IV. VIOXX® PRESCRIPTION INFORMATION

A. Who prescribed VIOXX® for you? _____

B. On which dates did you begin to take, and stop taking, VIOXX®? _____

C. Did you take VIOXX® continuously during that period?
Yes _____ No _____ Don't Recall _____

D. To your understanding, for what condition were you prescribed VIOXX®? _____

E. Did you renew your prescription for VIOXX®? Yes ____ No ____ Don't Recall ____

F. If you received any samples of VIOXX®, state who provided them, what dosage, how much and when they were provided: _____

G. Which form of VIOXX® did you take (check all that apply)?
_____ 12.5 mg Tablet (round, cream, MRK 74)
_____ 12.5 mg Oral Suspension
_____ 25 mg Tablet (round, yellow, MRK 110)
_____ 25 mg Oral Suspension
_____ 50 mg Tablet (round, orange, MRK 114)

H. How many times per day did you take VIOXX®?

_____

I. Did you request that any doctor or clinic provide you with VIOXX® or a prescription for VIOXX®? Yes ____ No ____ Don't Recall _____

J. Instructions or Warnings:

1. Did you receive any written or oral information about VIOXX® before you took it? Yes __ No ____ Don't Recall _____
2. Did you receive any written or oral information about VIOXX® while you took it? Yes ___ No _____ Don't Recall _____
3. ***If "yes,"***
    a. When did you receive that information?_____
    b. From whom did you receive it?_____
    c. What information did you receive? ____
    _____

K. What over-the-counter pain relief medications, if any, were you taking at the same time you were taking VIOXX®? _____
_____

V. MEDICAL BACKGROUND

A. Height: _____

B. Current Weight: _____
Weight at the time of the injury, illness, or disability described in Section I(C): _____

C. Smoking/Tobacco Use History: ***Check the answer and fill in the blanks applicable to your history of smoking and/or tobacco use.***

___ Never smoked cigarettes/cigars/pipe tobacco or used chewing tobacco/snuff.

___ Past smoker of cigarettes/cigars/pipe tobacco or used chewing tobacco/snuff.
    a. Date on which smoking/tobacco use ceased: _____
    b. Amount smoked or used: on average_____ per day for _____ years.

___ Current smoker of cigarettes/cigars/pipe tobacco or user of chewing tobacco/snuff.
    a. Amount smoked or used: on average _____ per day for _____ years.

___ Smoked different amounts at different times.

D. Drinking History. Do you now drink or have you in the past drank alcohol (beer, wine, whiskey, etc.)? Yes ____ No ____ ***If "yes," fill in the appropriate blank*** with the number of drinks that represents your average alcohol consumption during the period you were taking VIOXX® up to the time that you sustained the injuries alleged in the complaint:

_____ drinks per week,

_____ drinks per month,

_____ drinks per year, ***or***

Other (describe): _____

E. Illicit Drugs. Have you ever used (even one time) any illicit drugs of any kind within one (1) year before, or any time after, you first experienced your alleged VIOXX®-related injury?" Yes ____ No ____ Don't Recall _____

If "yes", identify each substance and state when you first and last used it. _____

_____

F. Please indicate to the best of your knowledge whether you have ever received any of the following treatments or diagnostic procedures:

1. Cardiovascular surgeries, including, but not limited to, the following, and specify for what condition the surgery was performed: open heart/bypass surgery, pacemaker implantation, vascular surgery, IVC filter placement, carotid (neck artery) surgery, lung resection, intestinal surgery:

Surgery	**Condition**	**When**	**Treating Physician**	**Hospital**

2. Treatments/interventions for heart attack, angina (chest pain), or lung ailments:

Treatment/Intervention	**When**	**Treating Physician**	**Hospital**

3. To your knowledge, have you had any of the following tests performed: chest X-ray, CT scan, MRI, angiogram, EKG, echocardiogram, TEE (trans-esophageal echo), bleeding scan, endoscopy, lung bronchoscopy, carotid duplex/ultrasound, MRI/MRA of the head/neck, angiogram of the head/neck, CT scan of the head, bubble/microbubble study, or Holter monitor?
   Yes _____ No _____ Don't Recall _____ ***If "yes,"*** answer the following:

Diagnostic Test	When	Treating Physician	Hospital	Reason

VI. DOCUMENTS

Please indicate if any of the following documents and things are currently in your possession, custody, or control, or in the possession, custody, or control of your lawyers by checking ***"yes"*** or ***"no."*** Where you have indicated ***"yes,"*** please attach the documents and things to your responses to this profile form.

A. Records of physicians, hospitals, pharmacies, and other healthcare providers identified in response to this profile form. Yes ____ No ____

B. Decedent's death certificate (if applicable). Yes ____ No ____

C. Report of autopsy of decedent (if applicable). Yes ____ No ____

VII. LIST OF MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

List the name and address of each of the following:

A. Your current family and/or primary care physician:

Name	Address

B. To the best of your ability, identify each of your primary care physicians for the last ten (10) years.

Name	Address	Approximate Dates

C. Each hospital, clinic, or healthcare facility where you have received inpatient treatment or been admitted as a patient during the last ten (10) years.

Name	Address	Admission Dates	Reason for Admission

D. Each hospital, clinic, or healthcare facility where you have received outpatient treatment (including treatment in an emergency room) during the last ten (10) years.

Name	Address	Admission Dates	Reason for Admission

E. Each physician or healthcare provider from whom you have received treatment in the last ten (10) years.

Name	Address	Dates of Treatment

F. Each pharmacy that has dispensed medication to you in the last ten (10) years.

Name	Address

G. If you have submitted a claim for social security disability benefits in the last ten (10) years, state the name and address of the office that is most likely to have records concerning your claim.

Name	Address

H. If you have submitted a claim for worker's compensation, state the name and address of the entity that is most likely to have records concerning your claim.

Name	Address

CERTIFICATION

I declare under penalty of perjury subject to 28 U.S.C. § 1746 that all of the information provided in this Profile Form is true and correct to the best of my knowledge, that I have completed the List of Medical Providers and Other Sources of Information appended hereto, which is true and correct to the best of my knowledge, that I have supplied all the documents requested in part VI of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and that I have supplied the authorizations attached to this declaration.

_____	_____	_____
Signature	Print Name	Date