GENERAL ADDENDUM

d. Other than the implantation of the Exactech product(s) at issue, have you had implanted in your body any other medical product of any kind (including joint-related and not joint-related implants, but excluding dental filings, crowns, and bridges)?

Check Yes/No: Yes No

If Yes, please state the following:

	Product 7	Product 8
Product Name		
Date of Implantation		
Name & Address of Implanting Surgeon	Name: Street: City: State: Zip:	Name: Street: City: State: Zip:
Condition Sought to be Treated		
Complications with Device or Procedure		
Still Implanted in Your Body Today		

	Product 9	Product 10
Product Name		
Date of Implantation		
Name & Address of Implanting Surgeon	Name: Street: City: State: Zip:	Name: Street: City: State: Zip:
Condition Sought to be Treated		
Complications with Device or Procedure		
Still Implanted in Your Body Today		

f. To the best of your recollection, list each prescription or over the counter medication, you have regularly taken (i.e., daily over the course of three months or more) in the five (5) years prior to your first implant surgery with an Exactech product to the present.

Medication	Start & End Dates of Use	Dose & Frequency	Prescribing Physician (if any)	Dispensing Pharmacy (if any)	Purpose
	to ☐ Present				
	to ☐ Present				
	to ☐ Present				
	to ☐ Present				
	to ☐ Present				
	to ☐ Present				

Medication	Start & End Dates of Use	Dose & Frequency	Prescribing Physician (if any)	Dispensing Pharmacy (if any)	Purpose
	to ☐ Present				
	to ☐ Present				
	to ☐ Present				
	to ☐ Present				
	to ☐ Present				
	to ☐ Present				

Medication	Start & End Dates of Use	Dose & Frequency	Prescribing Physician (if any)	Dispensing Pharmacy (if any)	Purpose
	to ☐ Present				
	to ☐ Present				
	to ☐ Present				
	to ☐ Present				
	to ☐ Present				
	to ☐ Present				

Medication	Start & End Dates of Use	Dose & Frequency	Prescribing Physician (if any)	Dispensing Pharmacy (if any)	Purpose
	to ☐ Present				
	to ☐ Present				
	to ☐ Present				
	to ☐ Present				
	to ☐ Present				
	to ☐ Present				

Medication	Start & End Dates of Use	Dose & Frequency	Prescribing Physician (if any)	Dispensing Pharmacy (if any)	Purpose
	to ☐ Present				
	to ☐ Present				
	to ☐ Present				
	to ☐ Present				
	to ☐ Present				
	to ☐ Present				

4. IMPLANT/EXPLANT INFORMATION

a. Please provide the following information regarding your implantation surgery(ies).

	Implantation Surgery 6
Name(s) and Address(es) of Implanting Surgeon(s):	Name: Street: City: State: Zip:
Name(s) and Address(es) of Hospital(s) or Clinic(s) where surgery performed:	Name: Street: City: State: Zip:
Date(s) of Surgery:	

	Implantation Surgery 7
Name(s) and Address(es) of Implanting Surgeon(s):	Name: Street: City: State: Zip:
Name(s) and Address(es) of Hospital(s) or Clinic(s) where surgery performed:	Name: Street: City: State: Zip:
Date(s) of Surgery:	

	Implantation Surgery 8
Name(s) and Address(es) of Implanting Surgeon(s):	Name: Street: City: State: Zip:
Name(s) and Address(es) of Hospital(s) or Clinic(s) where surgery performed:	Name: Street: City: State: Zip:
Date(s) of Surgery:	

	Implantation Surgery 9
Name(s) and Address(es) of Implanting Surgeon(s):	Name: Street: City: State: Zip:
Name(s) and Address(es) of Hospital(s) or Clinic(s) where surgery performed:	Name: Street: City: State: Zip:
Date(s) of Surgery:	

	Implantation Surgery 10
Name(s) and Address(es) of Implanting Surgeon(s):	Name: Street: City: State: Zip:
Name(s) and Address(es) of Hospital(s) or Clinic(s) where surgery performed:	Name: Street: City: State: Zip:
Date(s) of Surgery:	

b. With what type of prosthesis were you implanted? For each prosthesis, indicate on which side of your body it was implanted and the date(s) of implantation.

Type of Prosthesis	Date of Implantation	Right	Left
Optetrak Classic 3		☐	☐
Optetrak Classic 4		☐	☐
Optetrak Logic 3		☐	☐
Optetrak Logic 4		☐	☐
Truliant 3		☐	☐
Truliant 4		☐	☐
Vantage 3		☐	☐
Vantage 4		☐	☐
Connexion GXL 3		☐	☐
Connexion GXL 4		☐	☐
Conventional UHMWPE Hip Liner 3		☐	☐
Conventional UHMWPE Hip Liner 4		☐	☐

c. List the item number(s) and serial number(s) that corresponds to your prosthesis. Provide all codes, including those relating to the polyethylene component.

Prosthesis	Item Number(s)	Serial Number(s)

6. HEALTHCARE PROVIDERS

a. Identify each of the below whom you have seen for medical care and treatment for the period five (5 years) before your first implant surgery to the present, but for any medical care and treatment for any of your bones or joints, please answer the question for ten (10) years before your first implant surgery to the present

1) Doctor or healthcare provider (including but not limited to family/primary care physicians, physical therapists, and/or chiropractors);
2) Any hospital, clinic, surgery center, healthcare facility, physical therapy or rehabilitation facility; and
3) Any facility at which you have had radiographs of the joint(s), i.e., hip, knee, or ankle at issue (x-rays, ultrasounds, MRIs, CT scans, bone scans).

Healthcare Provider	Address	Dates/Years of Visits	Reason for Visit
	Street: City: State: Zip:	to ☐ Present	
	Street: City: State: Zip:	to ☐ Present	
	Street: City: State: Zip:	to ☐ Present	

Healthcare Provider	Address	Dates/Years of Visits	Reason for Visit
	Street: City: State: Zip:	to ☐ Present	
	Street: City: State: Zip:	to ☐ Present	
	Street: City: State: Zip:	to ☐ Present	
	Street: City: State: Zip:	to ☐ Present	
	Street: City: State: Zip:	to ☐ Present	