IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NEW YORK

IN RE: EXACTECH POLYETHYLENE ORTHOPEDIC PRODUCTS LIABILITY LITIGATION	)))))	MDL Docket No. 3044 THE HON. NICHOLAS G. GARAUFIS, U.S.D.J.

PLAINTIFF'S FACT SHEET

This Plaintiff's Fact Sheet ("PFS") must be completed by the plaintiff or the representative of plaintiff's decedent within 75 days of the filing of the Complaint or 75 days from the date of the implementation order, whichever is later. No objections may be made to the questions. Answer every question to the best of your knowledge. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, provide as much information as you can. You must supplement your responses if you learn that they change or are incomplete or incorrect in any material respect. For each question, where the space provided does not allow for a complete answer, attach additional sheets so that all answers are complete. When attaching additional sheets, clearly label what question your answer pertains to.

In filling out this form, use the following definitions: (1) "**health care provider**" means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care, and if claims are made for psychological, cognitive, and/or mental health problems other than "garden variety" emotional distress, psychiatric, or psychological care or advice, and any pharmacy, dietary, nutrition or weight loss, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, osteopath, homeopath, chiropractor, or other persons or entities involved in the evaluation, diagnosis, care, and/or treatment of the plaintiffor plaintiff's decedent;(2) "**document**" means any writing or record of every type that is in your possession, including but not limited to written documents, documents in electronic format, e-mail communications; text messages; social network or Internet postings, social network other app-based messages; iMessages, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phone records, non-identical copies, and other data compilations from which information can be obtained and translated, if necessary, by the defendants through electronic devices into reasonably usable form.

Information provided in this PFS will only be used for purposes related to this litigation and medical records will be destroyed upon the completion of the litigation provided that this individual case is dismissed with prejudice. This Fact Sheet is completed pursuant to the Federal Rules of Civil Procedure governing discovery (or, for state court case, the governing rules of the state in which the case is pending).

1. CASE INFORMATION

Name of Person Completing Form:	
If you are completing this PFS in a representative capacity (e.g., on behalf of the estate of a deceased person), please complete the following:	
Your Name:	
Other Names and the Dates You Used Those Names:	
Your Address:	Street: City: State: Zip:
Individual You Represent, and Your Capacity as Representative:	
Your Relationship to Individual You Represent:	
Court Who Appointed You as Representative (if any):	
Date You Were Appointed:	
Individual Case Number:	

THE REST OF THIS PLAINTIFF'S FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO WAS IMPLANTED WITH AN EXACTECH PRODUCT.

2. PERSONAL INFORMATION

Name:	
Maiden/Other Names Used:	

Current or Last Known Address:	Street: City: State: Zip:
Year You Began Living at This Address:	
All Persons Who Have Lived with You from the Date You Were First Implanted to the Present:	

Date of Birth:	Sex: Male: ☐ Female: ☐
Place of Birth:	Driver's License Number and Issuing State (for all driver's licenses you have):
Date of Death (if applicable):	Social Security Number:
Marital Status:	Name of Spouse, if Married at time of filing Complaint:

a. Identify each address at which you have resided at the time of your implant surgery with an Exactech device and also for the last five (5) years, and list the approximate years when you started and stopped living at each address:

Address	**Dates of Residence**
Street: City: State: Zip:	to ☐ Present

Address	Dates of Residence
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
Street: City: State: Zip:	to ☐ Present

b. Are you currently, or have you ever been, married or in a domestic partnership/civil union?

Check Yes/No: Yes ☐ No ☐

If Yes, for each spouse/partner, please state the following:

Name & Address of Spouse/Partner	Spouse/Partner's Date of Birth	Date Marriage/ Domestic Partnership Began and Ended	How Marriage/ Domestic Partnership Ended
Name: Street: City: State: Zip:		to ☐ Present	
Name: Street: City: State: Zip:		to ☐ Present	
Name: Street: City: State: Zip:		to ☐ Present	
Name: Street: City: State: Zip:		to ☐ Present	

c. For each of your living children, if any, list the following:

Child's Name	Date of Birth

d. Within the last ten (10) years, have you been convicted of, or plead guilty to, a felony of fraud or dishonesty and/or a crime of fraud or dishonesty?

Check Yes/No: Yes ☐ No ☐

If Yes, state the following:

Nature of Crime	Date of Crime	Location of Crime

3. MEDICAL BACKGROUND

Current height:	feet: inches:
Please state your weight at the following times:	Current:
	Time of each implant at issue:
	Time of each revision surgery (if any):

a. Have you ever had an allergic reaction? Check Yes/No: Yes ☐ No ☐

If Yes, please state the following:

Type of Allergy (e.g., food, drug, cosmetic)	When Allergy Was Diagnosed	Symptoms of Allergy	Name & Address of Health Care Provider Who Diagnosed Allergy	Treatment Received, If Any
			Name: Street: City: State: Zip:	
			Name: Street: City: State: Zip:	

Type of Allergy (e.g., food, drug, cosmetic)	When Allergy Was Diagnosed	Symptoms of Allergy	Name & Address of Health Care Provider Who Diagnosed Allergy	Treatment Received, If Any
			Name: Street: City: State: Zip:	
			Name: Street: City: State: Zip:	
			Name: Street: City: State: Zip:	
			Name: Street: City: State: Zip:	

b. Have you ever been diagnosed with any of the following?

Condition	Yes/No/Unknown	Name and Address of Diagnosing Provider	Approximate Date of Diagnosis (if applicable)
Acetabular perforation	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Adverse local tissue reaction (ALTR)	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Alcohol Addiction	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Aseptic Lymphocyte-Dominated Vasculitis-Associated Lesion (ALVAL)	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Asthma	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Avascular necrosis	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	

Condition	Yes/No/Unknown	Name and Address of Diagnosing Provider	Approximate Date of Diagnosis (if applicable)
Neck or spinal injury or condition	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Blood clots	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Bone fracture	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Cancer (including blood cancers)	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Charcot's disease	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Chronic Fatigue Syndrome	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	

Condition	Yes/No/Unknown	Name and Address of Diagnosing Provider	Approximate Date of Diagnosis (if applicable)
Colitis or Ulcerative Colitis	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Congenital dysplasia of the hip	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Crohn's Disease treated with medication	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Deep Vein Thrombosis (DVT)	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Degenerative joint or disc disease	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Diabetes	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	

Condition	Yes/No/Unknown	Name and Address of Diagnosing Provider	Approximate Date of Diagnosis (if applicable)
Drug addiction	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Eczema	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Femoral shaft perforation, fissure, or fracture	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Fibromyalgia	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Heart attack/ Myocardial infarction (MI)	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Hay fever	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	

Condition	Yes/No/Unknown	Name and Address of Diagnosing Provider	Approximate Date of Diagnosis (if applicable)
Immunodeficiency disorders	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Infections lasting longer than a week or occurring more frequently than monthly	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Inflammatory bowel disease	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Liver disease	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Lupus	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Lyme Disease	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	

Condition	Yes/No/Unknown	Name and Address of Diagnosing Provider	Approximate Date of Diagnosis (if applicable)
Neuromuscular compromise or vascular deficiency	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Osteolysis	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Paget's Disease	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Periarticular calcification or ossification	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Peripheral neuropathies or nerve damage	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Poor bone quality (e.g., osteoporosis)	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	

Condition	Yes/No/Unknown	Name and Address of Diagnosing Provider	Approximate Date of Diagnosis (if applicable)
Reflex Sympathetic Dystrophy Syndrome (RSDS) or Complex Regional Pain Syndrome (CRPS)	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Rheumatoid Arthritis	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Rheumatic Disorders or Diseases other than Rheumatoid Arthritis	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Renal insufficiency	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Skeletal hyperostosis	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Slipped Capital Femoral Epiphysis	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	

Condition	Yes/No/Unknown	Name and Address of Diagnosing Provider	Approximate Date of Diagnosis (if applicable)
Subluxation or dislocation of the hip joint	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Treatment with non-topical steroids for two consecutive months	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Trochanteric fracture	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	
Pseudotumor	☐ Yes ☐ No ☐ Unknown	Name: Street: City: State: Zip:	

c. Identify each hospital, clinic, surgery center, or healthcare facility where you have undergone a surgical procedure (whether in-patient or out-patient) from five (5) years before your first implant surgery to the present:

Name of Facility	Treating Physician and Address	Approximate Dates of Surgery or Procedure	Surgery or Procedure Performed
	Name: Street: City: State: Zip:		
	Name: Street: City: State: Zip:		
	Name: Street: City: State: Zip:		
	Name: Street: City: State: Zip:		

Name of Facility	Treating Physician and Address	Approximate Dates of Surgery or Procedure	Surgery or Procedure Performed
	Name: Street: City: State: Zip:		
	Name: Street: City: State: Zip:		
	Name: Street: City: State: Zip:		
	Name: Street: City: State: Zip:		

Name of Facility	Treating Physician and Address	Approximate Dates of Surgery or Procedure	Surgery or Procedure Performed
	Name: Street: City: State: Zip:		
	Name: Street: City: State: Zip:		
	Name: Street: City: State: Zip:		
	Name: Street: City: State: Zip:		

Name of Facility	Treating Physician and Address	Approximate Dates of Surgery or Procedure	Surgery or Procedure Performed
	Name: Street: City: State: Zip:		
	Name: Street: City: State: Zip:		
	Name: Street: City: State: Zip:		
	Name: Street: City: State: Zip:		

Name of Facility	Treating Physician and Address	Approximate Dates of Surgery or Procedure	Surgery or Procedure Performed
	Name: Street: City: State: Zip:		
	Name: Street: City: State: Zip:		
	Name: Street: City: State: Zip:		
	Name: Street: City: State: Zip:		

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 1	Product 2
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 3	Product 4
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 5	Product 6
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		

e. Have you ever participated in any clinical trial or studies relating to any medical devices, drugs, or treatments for any joint-related medical condition(s)?

Check Yes/No/Do not know: Yes ☐ No ☐ Do not know ☐

If Yes, please identify:

Name of Trial/Study	Sponsor of Trial/Study	Drug, Device, or Treatment Studied	Purpose of Drug, Device, or Treatment Studied	Dates You Participated in Trial/Study

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				

4. IMPLANT/EXPLANT INFORMATION

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

	Implantation Surgery 1
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 2
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 3
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 4
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 5
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		☐	☐
Optetrak Classic		☐	☐
Optetrak Logic		☐	☐
Optetrak Logic		☐	☐
Truliant		☐	☐
Truliant		☐	☐
Vantage		☐	☐
Vantage		☐	☐
Connexion GXL		☐	☐
Connexion GXL		☐	☐
Conventional UHMWPE Hip Liner		☐	☐
Conventional UHMWPE Hip Liner		☐	☐

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)

d. Describe the condition for which the Exactech product(s) at issue was/were implanted:

e. Identify the healthcare provider who diagnosed you with the above condition(s) by name and address:

_____

f. Provide the following information regarding your revision surgery(ies), if any.

	Revision Surgery 1	**Revision Surgery 2**
Date of Implant Surgery:		
Right/Left:	Right: ☐ Left: ☐	Right: ☐ Left: ☐
Date(s) of Revision Surgery:		
Name(s) and Address(es) of Revision Surgeon(s):	Name: Street: City: State: Zip:	Name: Street: City: State: Zip:
Name(s) and Address(es) of Revision Surgery Hospital(s):	Name: Street: City: State: Zip:	Name: Street: City: State: Zip:
Manufacturer(s) and Name/Model of Replacement Device(s):		

	Revision Surgery 3	Revision Surgery 4
Date of Implant Surgery:		
Right/Left:	Right: ☐ Left: ☐	Right: ☐ Left: ☐
Date(s) of Revision Surgery:		
Name(s) and Address(es) of Revision Surgeon(s):	Name: Street: City: State: Zip:	Name: Street: City: State: Zip:
Name(s) and Address(es) of Revision Surgery Hospital(s):	Name: Street: City: State: Zip:	Name: Street: City: State: Zip:
Manufacturer(s) and Name/Model of Replacement Device(s):		

	Revision Surgery 5	Revision Surgery 6
Date of Implant Surgery:		
Right/Left:	Right: ☐ Left: ☐	Right: ☐ Left: ☐
Date(s) of Revision Surgery:		
Name(s) and Address(es) of Revision Surgeon(s):	Name: Street: City: State: Zip:	Name: Street: City: State: Zip:
Name(s) and Address(es) of Revision Surgery Hospital(s):	Name: Street: City: State: Zip:	Name: Street: City: State: Zip:
Manufacturer(s) and Name/Model of Replacement Device(s):		

g. Identify who is currently in possession of your explanted components unless the Exactech product(s) at issue is/are in the possession of a consulting or testifying expert, in which case answer "in possession of expert" but do not reveal the identity of the expert:

h. If none of your Exactech product(s) has/have been explanted, has any doctor advised you that you will need to have your Exactech product(s) explanted at some time in the near future?

Check Yes/No: Yes ☐ No ☐

If Yes, state the following:

	Doctor 1	Doctor 2
Name of Doctor:		
Address of Doctor:	Street: City: State: Zip:	Street: City: State: Zip:
Reason for Recommending That Exactech Product(s) Be Explanted:		
Exactech Product(s) Recommended for Removal:		
Date You Were So Advised:		
Do You Intend to Have Your Device Explanted?	Yes ☐ No ☐	Yes ☐ No ☐
If Yes, When?		
If No, Why Not?		

	Doctor 3	Doctor 4
Name of Doctor:		
Address of Doctor:	Street: City: State: Zip:	Street: City: State: Zip:
Reason for Recommending That Exactech Product(s) Be Explanted:		
Exactech Product(s) Recommended for Removal:		
Date You Were So Advised:		
Do You Intend to Have Your Device Explanted?	Yes ☐ No ☐	Yes ☐ No ☐
If Yes, When?		
If No, Why Not?		

i. Was/were any imaging study(ies) (e.g., MRI/CT/Ultrasound) conducted in connection with your implant or revision surgery(ies)?

Check Yes/No: Yes ☐ No ☐

If Yes, list which reports are available and identify, if known, from which facilities.

---

j. Was/were any pathology study(ies) conducted in connection with your implant or revision surgery(ies)?

Check Yes/No: Yes ☐ No ☐

If Yes, list which reports and/or specimens are available:

---

5. CURRENT CLAIM INFORMATION

a. Do you allege that you experienced, or are currently experiencing, a physical and/or bodily condition or illness as a result of the Exactech product(s) at issue?

Check Yes/No: Yes ☐ No ☐

If Yes, please describe your physical and/or bodily conditions or illnesses and state whether you are currently experiencing the physical and/or bodily conditions or illnesses:

---

b. Do you claim that you have any of the below conditions as a result of your Exactech implant? If so mark "X" for all conditions that apply:

Condition	Left Side	Right Side
Bone loss requiring grafting	☐	☐
Constrained liner placement surgery	☐	☐
Damage to abductor muscle requiring surgical repair	☐	☐
Debridement of necrotic tissue	☐	☐
Disassociation of femoral head	☐	☐
DVT, Pulmonary Embolism, or Myocardial Infarction During Hospitalization for Revision Surgery or within 8 weeks after discharge	☐	☐
Effusion (excess fluid causing swollen knee)	☐	☐
Elevated Metal Ion Levels	☐	☐
Extended Trochanteric Osteotomy (for Femoral Stem Removal)	☐	☐
Femoral Stem Loosening	☐	☐
Foot Drop	☐	☐
Fracture (bone)	☐	☐
Fracture (femoral stem or femoral neck)	☐	☐
Girdlestone	☐	☐
Need for Hinge Knee Replacement	☐	☐
Hip Dislocation	☐	☐
Hip Dislocation-related Treatment: Closed Reduction *[Identify Number of Closed Reductions: ___]*	☐	☐
Hip Dislocation-related Treatment: Open Reduction *[Identify Number of Open Reductions: ___]*	☐	☐

Condition	Left Side	Right Side
Infection (in the hip, knee or ankle)	☐	☐
Infection (in the hip, knee or ankle) related Treatment: IV antibiotics	☐	☐
Infection (in the hip, knee or ankle) related Treatment: Surgery to Implant Antibiotic Spacer	☐	☐
Infection (in the hip, knee or ankle) related Treatment: Surgery to Place Wound Vacuum	☐	☐
Infection (in the hip, knee or ankle) related Treatment: Irrigation and Debridement (I&D) Surgery	☐	☐
Loosening of acetabular cup or polyethylene liner	☐	☐
Metallosis/Metal Wear/Corrosion	☐	☐
Nonunion fracture	☐	☐
Osteolysis	☐	☐
Pseudotumor	☐	☐
Placement of Cabling or Hardware for Femur Fracture	☐	☐
Re-Revision Surgery(ies)	☐	☐
Tibial Tray Loosening	☐	☐
Femur Fracture	☐	☐
Amputation	☐	☐
Death	☐	☐
Other (please describe):	☐	☐

c. For each condition or illness identified above, please state the following:

Condition	Approx. Date of Treatment	Name & Address of Treating Healthcare Provider
	to ☐ Present	Name: Street: City: State: Zip:
	to ☐ Present	Name: Street: City: State: Zip:
	to ☐ Present	Name: Street: City: State: Zip:
	to ☐ Present	Name: Street: City: State: Zip:
	to ☐ Present	Name: Street: City: State: Zip:
	to ☐ Present	Name: Street: City: State: Zip:

Condition	Approx. Date of Treatment	Name & Address of Treating Healthcare Provider
	to ☐ Present	Name: Street: City: State: Zip:
	to ☐ Present	Name: Street: City: State: Zip:
	to ☐ Present	Name: Street: City: State: Zip:
	to ☐ Present	Name: Street: City: State: Zip:
	to ☐ Present	Name: Street: City: State: Zip:
	to ☐ Present	Name: Street: City: State: Zip:

Condition	Approx. Date of Treatment	Name & Address of Treating Healthcare Provider
	to ☐ Present	Name: Street: City: State: Zip:
	to ☐ Present	Name: Street: City: State: Zip:
	to ☐ Present	Name: Street: City: State: Zip:
	to ☐ Present	Name: Street: City: State: Zip:
	to ☐ Present	Name: Street: City: State: Zip:
	to ☐ Present	Name: Street: City: State: Zip:

d. Describe any activities (i.e., of daily living, vocation, or recreation) that you can no longer perform or participate in, or cannot perform or participate in as well or actively in the past, since the time you experienced the physical and/or bodily condition(s) or illness(es):

_____

e. Do you allege that the Exactech product(s) at issue worsened a previously existing condition?

Check Yes/No: Yes ☐ No ☐

If Yes, describe the previously existing condition, the approximate date of onset of the previously existing condition, and any treatment for and resolution of the previously existing condition:

Previously Existing Condition	Approx. Date of Onset	Treatment for and Resolution

Previously Existing Condition	Approx. Date of Onset	Treatment for and Resolution

f. Have you or anyone acting on your behalf, other than your attorney, ever communicated directly with, or received communications directly from Broadspire?

Check Yes/No: Yes ☐ No ☐

If YES, state the approximate date of the first communication.

---

g. Have you or anyone acting on your behalf, other than your attorney, ever communicated directly with or received communications directly from any Exactech representative or lawyer, whether face-to-face, by telephone, or written communication?

Check Yes/No: Yes ☐ No ☐

If Yes, please state the following:

Date of Communication	Name of Person with Whom You Communicated	Mode of Communication	Describe Substance of Communication

h. Did you read or rely upon any documents or other information from Exactech prior to the date of your Exactech product implantation surgery?

Check Yes/No: Yes ☐ No ☐

If Yes, for each, please state the following:

Document/Source of Information	Date You Read Document/Received Information	How You Obtained Document/Information

If you have a copy of any of the documents that you listed, please produce a copy of it together with your answers to the Plaintiff's Fact Sheet.

If you no longer have the document or written information, please describe the information that you received to the best of your recollection:

i. Did you read or rely upon any documents or other information specifically relating to the Exactech product(s) implanted prior to your surgery?

Check Yes/No: Yes ☐ No ☐

If Yes, please state the following:

Document/Source of Information	Date You Read Document/Received Information	How You Obtained Document/Information

If you have a copy of any of the documents that you listed, please produce a copy of it together with your answers to the Plaintiff's Fact Sheet.

If you no longer have the document or written information, please describe the information that you received to the best of your recollection:

j. Were you given any oral or written instructions, warnings, or other information on the Exactech product(s) and/or the implantation of the Exactech product(s)?

Check Yes/No/Do not recall: Yes ☐ No ☐ Do not recall ☐

If Yes, please state the following:

When Did You Receive the Information?	Who Gave You the Information?	Oral or Written	Do You Have a Copy of This Document?

If you have a copy of any of the information that you listed, please produce a copy of it together with your answers to the Plaintiff's Fact Sheet.

If you no longer have the document or written information, please describe the information that you received to the best of your recollection:

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	

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	

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	

7. PSYCHOLOGICAL, COGNITIVE, MENTAL, AND/OR EMOTIONAL DISTRESS CLAIMS

[NOTE: All plaintiffs must answer Question (a) below. If the answer to Question (a) is "No", please skip to Section 8 – Economic Damages. If the answer to Question (a) is "Yes", please answer Questions (b)–(d) below.]

a. Do you claim emotional distress damages in this lawsuit? Check Yes/No: Yes ☐ No ☐

b. Do you claim damages in this lawsuit for psychological, cognitive, and/or mental health problems, (including depression) or aggravation or exacerbation of a pre-existing mental health condition?
Check Yes/No: Yes ☐ No ☐

c. If you answered "yes" to question b above, have you been treated for any psychological, cognitive, and/or mental health problems including depression, (but excluding *emotional distress*) conditions or illnesses prior to developing the condition(s) alleged in this lawsuit?
Check Yes/No: Yes ☐ No ☐
If you answered "yes" to both questions b and c above, please state the following:

Name & Address of Each Healthcare Provider Who Treated You	Conditions for Which You Were Treated	Dates (month & year) Treated:
Name: Street: City: State: Zip:		
Name: Street: City: State: Zip:		

Name & Address of Each Healthcare Provider Who Treated You	Conditions for Which You Were Treated	Dates (month & year) Treated:
Name: Street: City: State: Zip:		
Name: Street: City: State: Zip:		
Name: Street: City: State: Zip:		
Name: Street: City: State: Zip:		

Name & Address of Each Healthcare Provider Who Treated You	Conditions for Which You Were Treated	Dates (month & year) Treated:
Name: Street: City: State: Zip:		
Name: Street: City: State: Zip:		
Name: Street: City: State: Zip:		
Name: Street: City: State: Zip:		

8. EDUCATIONAL BACKGROUND

a. Identify the following information for each school or other educational institution you have attended, starting with high school:

Name of School/ Educational Institution	City and State	Dates of Attendance	Highest Level of Education Completed
	City: State:	to ☐ Present	
	City: State:	to ☐ Present	
	City: State:	to ☐ Present	
	City: State:	to ☐ Present	
	City: State:	to ☐ Present	
	City: State:	to ☐ Present	
	City: State:	to ☐ Present	

9. ECONOMIC LOSS CLAIMS

a. Current employment:

Are you currently employed?	Yes ☐ No ☐
If yes, identify your current employer and position:	

b. Prior employment:

For the period of time from five (5) years before your first revision surgery until the present, please identify the following information for your employers. If you have not been revised, please identify the information for the past five (5) years from today.

Name of Employer	City and State	Approximate Dates of Employment	Occupation or Job Title	Reason for Leaving
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		

Name of Employer	City and State	Approximate Dates of Employment	Occupation or Job Title	Reason for Leaving
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		

c. Are you making a claim for past or future lost wages and/or loss of earning capacity?

Check Yes/No: Yes ☐ No ☐

If Yes, describe your claim(s). Your description should include the total amount of time (and amount of income) you have lost or will lose from work as a result of any condition that you claim or believe was caused by the Exactech product(s) at issue, and an explanation of how those amounts were calculated:

_____

If you claim a loss of earnings, state your earned income from five (5) years prior to your first revision surgery through the present. If you have not been revised, provide the information for the past five (5) years from the present.

Year	Annual Gross Income

Year	Annual Gross Income

d. Provide the following information for any other economic damages you are claiming:

Nature of Other Economic Damage	Approx. Dollar Amount

10. MILITARY BACKGROUND

Have you ever served in any branch of the U.S. Military?	Yes ☐ No ☐
If yes, identify branch, rank, and dates of service:	
If yes, select discharge status:	
Were you ever denied entry into the military for any reason relating to your medical or physical condition?	Yes ☐ No ☐

Were you ever discharged from the military for any reason relating to your medical or physical condition?	Yes ☐ No ☐
If you answered "yes" to either of the previous two questions, state the condition(s) and reasons for which you were denied entry or discharged:	

11. SOCIAL HISTORY

a. Do you currently use, or have you used, tobacco, including cigarettes, cigars, pipes, chewing tobacco/snuff, and/or electronic cigarettes?

Check Yes/No: Yes ☐ No ☐

If Yes, identify the following information:

Type of Tobacco	Date Tobacco Use Started	Amount Used on Average Per Day	Duration of Use

b. In the five years before your revision surgery, have you regularly consumed alcohol more than twice a week?

Check Yes/No: Yes ☐ No ☐

If Yes, identify the following information:

Average Amount Consumed Per Week	Approx. Dates of Use
	to ☐ Present
	to ☐ Present
	to ☐ Present
	to ☐ Present
	to ☐ Present
	to ☐ Present
	to ☐ Present
	to ☐ Present

c. Have you ever had a personal website, blog, Facebook account, Instagram account, Snapchat account, LinkedIn account, or any other social media?

Check Yes/No: Yes ☐ No ☐

If you answered Yes, please supply for the period of five (5) years before your first revision surgery to the present. If you haven't revised, please supply the information for the past five (5) years to the present.

Web Address/Account Name	Type of Social Media

d. For the period from five (5) years before your first implant surgery to the present, please list any sport or exercise activities in which you have regularly participated in:

Type of Sport/Exercise	Dates/Years Played or Exercised	Approx. Number of Hours Played or Exercised Per Week
	to ☐ Present	
	to ☐ Present	
	to ☐ Present	
	to ☐ Present	
	to ☐ Present	
	to ☐ Present	

Type of Sport/Exercise	Dates/Years Played or Exercised	Approx. Number of Hours Played or Exercised Per Week
	to ☐ Present	
	to ☐ Present	
	to ☐ Present	
	to ☐ Present	
	to ☐ Present	
	to ☐ Present	
	to ☐ Present	

e. Please list any activities identified in the previous question that you can no longer perform, or cannot perform as well, which you allege is due to your implants which are the subject of this lawsuit:

---

12. <u>INSURANCE INFORMATION</u>

a. Are you currently or have you ever been enrolled in Medicare or Medicaid?

Check Yes/No: Yes ☐ No ☐

[NOTE: If you are not currently a Medicare-eligible beneficiary but become eligible for Medicare during the pendency of this lawsuit, you must supplement your response at that time. This information is necessary for all parties to comply with Medicare regulations. See 42 U.S.C. § 1395y(b)(8), also known as Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 and 42 U.S.C. § 1395y(b)(2), also known as the Medicare Secondary Payer Act.]

If Yes, please state the following:

Health Insurance Claim Number (HICN):	
Date (month/year) You Began Receiving Medicare Benefits:	
Date (month/year) You Began Receiving Medicaid Benefits:	

b. Identify any insurance company or other entity that provided medical coverage to you (either directly or through a group, including any employer) or paid medical bills on your behalf at any time, for the injuries you allege are related to your implant:

Name of Entity	Identification and/or Policy Number	Name of Policy Holder/Insured (if different than you)	Approx. Dates of Coverage
			to ☐ Present
			to ☐ Present
			to ☐ Present

c. Have you ever received or applied for workers' compensation or social security, and/or state or federal disability benefits?

Check Yes/No: Yes ☐ No ☐

If Yes, as to each application separately, state the following:

	Application 1	Application 2	Application 3
Date/Year of Application:			
Place of Employment (name/address):	Name: Street: City: State: Zip:	Name: Street: City: State: Zip:	Name: Street: City: State: Zip:
Job Description at Time of Application:			

	Application 1	Application 2	Application 3
Type of Benefits:			
Nature of Claimed Injury/Disability:			
Period of Disability:			
Amount Awarded (if any):			
Basis of Your Claim:			
Claim Denied?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Agency/Company Application Was Submitted To:			
Claim/Docket Number, if Known:			

13. <u>OTHER CLAIM INFORMATION</u>

a. Have you ever been involved in an accident or other event as a result of which you sustained any physical injuries to your legs, hips, spine, back, knees, or pelvic area?

Check Yes/No: Yes ☐ No ☐

If Yes, please provide the following information and attach copies of any accident reports in your possession:

Date of Accident	Location & Type of Accident	Type & Location of Injury	Activity at Time of Injury	Names & Address of Treating Physician
				Name: Street: City: State: Zip:

Date of Accident	Location & Type of Accident	Type & Location of Injury	Activity at Time of Injury	Names & Address of Treating Physician
				Name: Street: City: State: Zip:
				Name: Street: City: State: Zip:
				Name: Street: City: State: Zip:
				Name: Street: City: State: Zip:

b. Have you ever filed a lawsuit or made a claim against anyone related to any bodily injuries, including but not limited to a medical malpractice lawsuit or a lawsuit against a pharmaceutical and/or medical device company?

Check Yes/No: Yes ☐ No ☐

If Yes, please provide the following:

Parties You Sued/Made Claim Against	Court in Which Suit Filed/Made Claim	Case/Claim Number	Attorney Who Represented You	Nature of Claim and Injury

c. Have you or your spouse/partner (if the spouse/partner is a plaintiff) ever declared personal bankruptcy since the date of your first implant surgery to the present?

Check Yes/No: Yes ☐ No ☐

If Yes, please state the following:

Date Filed:	
Court Filed:	
Docket Number of Petition:	
Orders of Discharge:	

d. Do you have litigation funding where the funder has decision making authority over the terms of any settlement or other resolution of your claim?

Check Yes/No: Yes ☐ No ☐

If Yes, please state the following:

Name & Address of Third Party:	Name: Street: City: State: Zip:
Basis for Decision Making Authority:	

14. POTENTIAL FACT WITNESSES

a. Identify each person who you believe possesses information concerning the facts of your lawsuit, including your current medical conditions, other than your healthcare providers:

Name	Address	Relationship to You
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	

15. DECEASED INDIVIDUALS & AUTOPSY INFORMATION

a. Are you filling this PFS out on behalf of an individual who is deceased and/or on whom an autopsy was performed?

Check Yes/No: Yes ☐ No ☐

If Yes, please state the following from the individual's Death Certificate and/or Autopsy Report:

[NOTE: In addition to the following, please attach a copy of the death certificate, the letters of administration, and a copy of the autopsy report (if applicable).]

Date of Death:	
Place of Death (city, state, and country):	City: State: Country:
Facility/Location Where Death Occurred:	
Name of Physician Who Signed Death Certificate:	
Cause of Death Listed on the Certificate:	
Date of Autopsy:	
Name of Physician Who Performed Autopsy:	

16. AUTHORIZATIONS AND DOCUMENT DEMANDS

Plaintiff agrees to produce copies of signed and dated authorizations to the extent applicable at the time of service of this PFS for the releases listed below. Plaintiff agrees that any document request for records to be produced by plaintiff will not preclude defendant from also collecting such records directly from the source pursuant to the signed authorizations.

DOCUMENT DEMANDS

Produce copies of the following documents that are in your current possession and to the extent the documents are not subject to and protected by any claim of privilege:

1. Copies of all medical records from any physicians, hospital, or healthcare provider who has treated you for any condition, illness, and/or disease identified in response to this PFS.
2. Copies of all records from any healthcare provider identified in response to this PFS.
3. All radiographs (x-rays, ultrasounds, MRI's, CT scans, etc.) that relate to any of Plaintiff's joints, back, or spine, as well as any pre- and post-implant radiology for any organ to which Plaintiff makes a claim.
4. All documents and/or notices received by Plaintiff with respect to third party lienholders, including but not limited to, insurance companies, workers' compensation, Medicare/Medicaid, and/or other governmental entities.
5. Copies of advertisements, informational brochures, or promotions that you saw or reviewed prior to your implant surgery discussing implant surgery or implant components.
6. All documents regarding the health risks associated with your implant surgery at or before the time of injury alleged in your Complaint, other than documents prepared by your attorney in this action.
7. All document that you believe were provided to you (not by your lawyer) by any defendant.
8. All photographs or videos of Plaintiff's surgery(ies), all photographs or videos depicting the Exactech product(s) at issue, and representative photographs and videos of Plaintiff which show Plaintiff's condition since the date of the original implantation(s).
9. Any documents, including but not limited to, literature or warnings received by you from surgeons, physicians, or other healthcare professionals who have treated you for any condition related to the Exactech product(s).
10. Documents that relate in any way to your application for, or award of, workers' compensation benefits for any injury or condition related to your impacted joint during the period from ten (10) years before your first implant surgery to the present.
11. Copies of any accident report(s) related to any accident or event, in which or as a result of which you sustained any personal injuries to your legs, hips, spine, knees, ankles, or pelvic area for the ten (10) years before your first implant surgery to the present.
12. All bankruptcy petitions and orders of discharge (if applicable) for all bankruptcy claims made by you or your spouse/partner if he/she is a plaintiff since the date of your first implant surgery.

13. Copies of all pleadings and deposition transcripts in your possession or the possession of any attorney who represented you related to any lawsuit or claim against anyone related to any injury to your hip, pelvis, spine, or legs that are not subject to confidentiality requirements from a non-party.

14. If applicable, decedent's death certificate and copies of letters testamentary or letters of administration confirming standing of the named plaintiff.

AUTHORIZATIONS FOR RELEASE OF INFORMATION

In addition to producing records responsive to the above demands, the plaintiff who was implanted with the Exactech product(s) at issue is also required to complete and sign the below-referenced authorizations, if applicable, and as identified by the plaintiff in his/her responses to the Plaintiff Fact Sheet:

Authorization	Attachment	Requirement
Authorization to Disclose Protected Health Information (i.e., medical records)	A	To be signed by all plaintiffs.
Authorization for the Release of Adverse Event Reports	B	To be signed by all plaintiffs.
Authorization to Disclose Psychological Records/Psychotherapy Notes	C	To be signed *only if* a plaintiff is claiming psychological or mental health damages per Section 7 of the PFS *for reasons related to the Exactech product(s) at issue.*
Authorization to Disclose Employment Information	D	To be signed *only if* a plaintiff is claiming lost wages or loss of earning capacity per Section 9 of the PFS.
Authorization to Disclose Worker's Compensation Information	E	To be signed *only if* a plaintiff has filed for worker's compensation benefits per Section 12 of the PFS *for reasons related to the plaintiff's joint(s) at issue in this lawsuit.*
Request for Copy of Tax Return	F	To be signed *only if* a plaintiff is claiming lost wages or loss of earning capacity damages per Section 9 of the PFS.
Social Security Administration (SSA) Consent for Release of Information	G	To be signed *only if* a plaintiff has filed for a claim for disability benefits per Section 12 of the PFS.
Request for Social Security Earnings Information	H	To be signed *only if* a plaintiff is claiming lost wages or loss of earning capacity damages per Section 9 of the PFS.

DECLARATION

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information and belief formed after due diligence and reasonable inquiry, that I have supplied all the documents requested in this Plaintiff Fact Sheet, to the extent that such documents are in my possession, and that I have supplied/will supply the Authorizations attached to this declaration, in accordance with the terms of this Plaintiff Fact Sheet.

_____ _____

Signature Date

_____

Print Name

17. LOSS OF CONSORTIUM PLAINTIFFS

a. State the following:

Your Name:	
Other Names and the Dates You Used Those Names:	
Did you live with the primary plaintiff at the time the alleged injury occurred?	Yes ☐ No ☐
Sex:	Male ☐ Female ☐

b. Have you sustained a loss of consortium, care, services, companionship, counsel, advice, assistance, comfort, or any similar loss for which you contend that Exactech should pay you compensation?

Check Yes/No: Yes ☐ No ☐

If Yes, do you contend that you have sustained, or will you sustain in the future, a loss of wages or income attributable to your loss?

Check Yes/No: Yes ☐ No ☐

LOSS OF CONSORTIUM PLAINTIFF DECLARATION

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the information provided in Section 17 of this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information, and belief.

_____ _____

Signature Date

_____

Print Name