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U.S. DISTRICT COURT
N.D. OF ALABAMA

Exhibit 1

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ALABAMA
SOUTHERN DIVISION

IN RE: CHANTIX (VARENICLINE) PRODUCTS LIABILITY LITIGATION	Master File No.: 2:09-CV-2039-IPJ MDL No. 2092
This Fact Sheet Relates To: MDL Case No. _____	Plaintiff: _____ (full name)

PLAINTIFF'S FACT SHEET

This Fact Sheet must be completed by each plaintiff who has filed a lawsuit related to his/her use of Chantix or as the representative of a person or the estate of a deceased person who used Chantix. Please 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, please provide as much information as you can. You must supplement your responses if you learn that they are incomplete or incorrect in any material respect. For each question, where the space provided does not allow for a complete answer, please attach additional sheets so that all answers are complete.

Information provided by plaintiff will only be used for purposes related to this litigation and may be disclosed only as permitted by the protective order in this litigation. This Fact Sheet is completed pursuant to the Federal Rules of Civil Procedure governing discovery (or, for state court cases, the governing rules of civil procedure of the state in which the case is pending).

I. CASE INFORMATION

A. Please provide the following information for the civil action which you filed:

1. Case Caption: _____

2. Court Case Number: _____

3. Court in which action was originally filed: _____

4. Court in which action is pending now: _____

5. Please state the name, address, telephone number, fax number, and e-mail address of principal attorney representing you:

Attorney Name: _____

Firm: _____

Address: _____

Telephone Number: _____

Fax Number: _____

E-Mail Address: _____

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

Your name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

In what capacity are you representing the individual? _____

If you were appointed by a court, state the:

State, Court Term and Number: _____

Date of Appointment: _____

Your relationship to the represented person: _____

If applicable, state the date and place of death of the decedent:

_____

If you are claiming the wrongful death of a family member, identify any and all heirs of that person:

_____

_____

[If you are completing this questionnaire in a representative capacity, please respond to the remaining questions with respect to the person who used Chantix. Those questions using the term "You" refer to the person who used Chantix. If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.]

II. CLAIM INFORMATION

A. Do you claim that you suffer or have suffered any physical, mental, psychological, psychiatric, cognitive, or emotional injuries, illnesses, or disabilities that you believe were caused by Chantix? Yes: _____ No: _____

If yes, for each injury, please provide the following information:

Describe the nature of your injury, illness or disability: _____

_____

When did you first experience any symptoms you believe are related to that injury?

_____

What is the name and address of the first person you contacted about your symptoms?

_____

Date(s) of diagnosis (if any): _____

Medications prescribed: _____

Did you receive any treatment other than medication? Yes: ____ No: ____

If yes, please describe the other treatment received:

_____

Name of physician, psychiatrist, or other health care provider who first diagnosed you:

_____

Address: _____

Treating physician (if different): _____

Address: _____

Were you hospitalized at the time of the diagnosis? Yes: _____ No: _____

If yes, please provide the following information:

Hospital name and address: _____

_____

Date of admission: _____ Date of discharge: _____

B. Does the injury, illness, or disability persist today? Yes: ____ No: _____

If yes, identify the current symptoms, the treatment you continue to receive, and the physician(s) providing treatment:

Current symptoms: _____

Medications currently taking: _____

Other treatment currently receiving: _____

Treating physician (if different from above): _____

Address (if not otherwise provided): _____

_____

C. Do you allege that Chantix caused you to attempt suicide (or caused the decedent to commit suicide)? Yes: ____ No: _____

If you answered "Yes," please complete the following:

Date you attempted suicide / decedent committed suicide: _____

Means by which you attempted suicide / decedent committed suicide: _____

_____

Were any toxicology tests performed? Yes: ____ No: _____

If so, what were the results? _____

If decedent committed suicide: Was an autopsy performed? Yes: ___ No: ____

Was any law enforcement official, governmental official, or other individual present at the time of the incident or respond to the incident? If yes, please list such persons.

_____

_____

Were there any individuals who had contact with you or would have knowledge of your behavior or mental state in the 72 hours immediately preceding your suicide attempt (or decedent's suicide)? If so, please identify their name, address, and relationship to you.

_____

_____

D. Lost Earnings: Do you claim that you lost earnings or suffered impairment of earning capacity as a result of any condition that you believe was caused by Chantix?
Yes: _____ No: _____ If you answered "Yes," please answer the following:

State the total amount of time you have lost from work as a result of any condition you claim was caused by Chantix.

_____

State the annual gross income you derived from your employment for each of the last five (5) years (or attach your federal tax returns for each of the last five (5) years).

_____

State the amount of income you claim you lost as a result of any condition you claim was caused by Chantix.

_____

E. Medical Expenses: Please list all of your medical expenses, including amounts billed or paid by insurers and other third-party payors, which are related to any condition which you claim was caused by Chantix for which you seek recovery in the action which you have filed. $ _____

F. Chantix Use: Identify by name and address the physician, psychiatrist, or other health care professional(s) who prescribed Chantix for you, the dosage and date(s) during which he or she prescribed Chantix, and the dosage and date(s) you took Chantix:

Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____ Phone: _____

Hospital Affiliation (if any): _____

Reason for Prescription: _____

Date Prescribed: _____ Dosage Prescribed: _____

Date(s) Used: _____

During you visit to the prescribing doctor's office, were you provided any written information about Chantix by the doctor or his or her staff?

Yes: _____ No: _____ Do Not Recall: _____

If you answered "Yes," please describe the document you received:

_____

_____

During you visit to the prescribing doctor's office, were you told anything about Chantix by the doctor or his / her staff?

Yes: _____ No: _____ Do Not Recall: _____

If you answered "Yes," please identify each person who told you anything about Chantix and describe what he or she told you:

_____

_____

G. Have you had discussions with any physician, psychiatrist, or other health care professional about whether your condition is related to Chantix?

Yes: _____ No: _____ Don't know: _____ If yes, please identify:

Name of health care professional: _____

Address: _____

Date of discussion: _____

What were you told? Please check one of the following:

1. _____ I was told my condition is related to Chantix.
2. _____ I was told my condition is not related to Chantix.
3. _____ I was told my condition may be related to Chantix.
4. _____ I was told by the doctor that he or she does not know whether my condition is related to Chantix.
5. _____ I don't recall what I was told.
6. _____ Other (describe discussion regarding Chantix):

_____

(If discussed with more than one doctor, please answer for each doctor, using additional pages as necessary.)

III. PERSONAL INFORMATION OF CHANTIX USER

A. Background Information:

Name: _____

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

_____

Social Security Number: _____

Medicare Health Insurance Claim Number (if applicable): _____

Identify each address at which you have resided during the last ten (10) years and the approximate dates during which you lived at each one (most recent first):

Street Address	City, State, Zip	Dates Resided	
		From	To

Date and Place of Birth: _____

Sex: Male _____ Female _____

Do you have a driver's license? Yes: _____ No: _____

Have you ever had your driving privileges suspended or limited based on your health or physical condition? Yes: _____ No: _____

If so, when and for what reason(s)? _____

_____

B. Family Information:

1. Have you ever been married? Yes: _____ No: _____

If you have been married, for each spouse, state:

Spouse's Name	Date of Marriage	Date Marriage Ended	Spouse's Date of Birth	Spouse's Occupation	Spouse's Present Address

2. Has your spouse filed a loss of consortium or other claim in this lawsuit?

Yes: _____ No: _____

3. If you have children, please identify each child's name and date of birth:

_____

_____

_____

C. Employment History:

Current occupation: _____

Please identify each of your employers over the past ten (10) years, including the dates of each such employment and positions held (most recent first):

Employer	**Address**	**Type of Business & Position**	**Dates of Employment**

Have you ever been out of work for more than thirty (30) days for reasons related to your health? Yes: _____ No: _____

If yes, please state the dates, employer, and health condition:

_____

_____

In the year prior to any injury you claim was caused by Chantix:

Were you fired, demoted, or suspended? Yes: _____ No: _____

Did you receive any negative performance reviews? Yes: _____ No: _____

If you answered "Yes" to any of the above questions, please describe the circumstances:

_____

_____

D. Educational History:

Identify each high school, vocational school, college, university or other post-secondary educational institution you have attended, the dates of attendance, and diplomas or degrees awarded:

School	Dates of Attendance	Diplomas/Degree Awarded

E. Military Service:

1. Have you ever served in any branch of the military? Yes: _____ No: _____

2. Branch and dates of service:

_____

3. Were you discharged for any reason relating to your health (whether physical, psychiatric or other health condition)?

   Yes: _____ No: _____

   If yes, state the condition:

   _____

4. Have you ever been rejected from military service for any reason relating to your health (whether physical, psychiatric, or other health condition)?

   Yes: _____ No: _____

F. Worker's Compensation Claims: Have you ever filed a worker's compensation claim?

Yes: _____ No: _____ If yes, please state:

Year claim was filed: _____

Where claim was filed: _____

Claim/docket number, if applicable: _____

Nature of claimed injury: _____

Period of disability: _____

[Attach additional sheets as necessary to describe more than one claim.]

G. Social Security Disability Claims: Have you ever made a social security disability claim?

Yes: _____ No: _____ If yes, please state:

Year claim was filed: _____

Where claim was filed: _____

Nature of disability: _____

Period of disability: _____

[Attach additional sheets as necessary to describe more than one clam.]

H. Other Disability Claims: Have you ever made any other form of disability claim?

Yes: ____ No: _____ If yes, please state:

Year claim was filed: _____

Where claim was filed: _____

Name of insurer/employer or other party to whom claim was made:

_____

Nature of disability: _____

Period of disability: _____

I. Life Insurance: Have you ever been denied life insurance? Yes: _____ No: _____
If yes, please state when, the name of the company, and the company's stated reason for denial (if any).

_____

_____

J. Other Lawsuits: Within the last ten (10) years, have you filed a lawsuit or made a claim, *other than* in the present suit? Yes: _____ No: _____

If yes, state: (1) the state and county in which claim was filed, (2) the caption, case name and/or names of adverse parties, (3) the civil action or docket number assigned to each such claim, action or suit, (4) the claims you made in that suit, and (5) the current status of the claim.

_____

_____

_____

K. Prior Convictions: Have you ever been convicted of, or pled guilty (or no contest) to, a felony and/or a crime involving fraud or dishonesty within the last ten (10) years?

Yes: _____ No: _____ If so, please describe: (1) the crime or offense, (2) the state and county in you were which convicted or pled, (3) the date on which you were convicted or pled guilty, and (4) the sentence or other outcome.

_____

_____

L. Computer Use: Have you had access to a computer at any time during the past five (5) years? Yes: _____ No: _____ If "yes," then answer the following:

Did you ever visit any website containing information regarding Chantix, other smoking cessation products, help quitting smoking, or the risks of smoking?

Yes: _____ No: _____ Do Not Recall: _____

Did you ever communicate via email or visit any chat rooms regarding Chantix, other smoking cessation products, help quitting smoking, or the risks of smoking?

Yes: _____ No: _____ Do Not Recall: _____

IV. LIST OF HEALTHCARE PROVIDERS

A. Health Care Providers (Including Mental Health Care Providers): Identify each physician, doctor, or other health care provider (including any psychiatrist, psychologist, therapist, counselor, or other mental health care provider) who has provided treatment to you for any reason in the past ten (10) years and the reason for consulting the health care provider or mental health care provider (attach additional sheets as needed).

Name	Address	Approximate Dates	Reason for Consultation

B. Hospitals, Clinics, & Other Facilities: Identify each hospital, clinic, or healthcare facility where you have received inpatient or outpatient treatment (including emergency room treatment) in the past ten (10) years (attach additional sheets as needed):

Name	Address	Approximate Dates	Reason for Treatment

C. Pharmacies: Identify each pharmacy, drugstore and/or other supplier (including mail order) where you have had prescriptions filled or from which you have ever received any prescription medication since in the past ten (10) years (attached additional sheets as needed):

Name of Pharmacy	Address of Pharmacy	Approximate Dates

D. Insurance Carriers: Identify each health insurance carrier which provided you with medical coverage and/or pharmacy benefits for the last ten (10) years, with the named insured and named insured's social security number (attach additional sheets as needed).

Carrier	Address	Name of Insured & SSN (if not Chantix user)	Policy Number

E. Other Witnesses: Other than those previously identified, please identify all persons who you believe possess information concerning your injury and/or your current medical condition. For each person, please state their name, address, phone number, relationship to you, and the information you believe they possess (attach additional sheets as needed).

Name	Address (including City, State, Zip) and Phone Number	Relationship	Information you believe they possess

Name	Address (including City, State, Zip) and Phone Number	Relationship	Information you believe they possess

V. PLAINTIFF'S HEALTH HISTORY

A. Over the past ten (10) years, have you experienced or been diagnosed or treated for any injuries, illnesses or disabilities (whether physical, psychiatric, or otherwise) ***other than*** those that you believe were caused by Chantix? Yes: _____ No: _____

If yes, for each injury, please provide the following information (attach additional sheets as needed):

Injury, illness, or disability	When first experienced symptoms	When first diagnosed	Name(s) of health care provider(s) who treated and/or diagnosed	Treatment received (including medications, if any)	Do you suffer from this condition today (Y/N)?

B. Please indicate whether to the best of your knowledge you have ever experienced or been diagnosed or treated for:

1. Mental health conditions, including but not limited to:

Aggressive/violent behavior	Yes: _____	No: _____
Anxiety (on at least a periodic basis)	Yes: _____	No: _____
Attention Deficit/Hyperactivity Disorder	Yes: _____	No: _____
Bi-polar disorder	Yes: _____	No: _____
Depression (on at least a periodic basis)	Yes: _____	No: _____
Personality disorders	Yes: _____	No: _____
Psychosis or psychiatric illnesses	Yes: _____	No: _____
Schizophrenia	Yes: _____	No: _____
Suicide attempt	Yes: _____	No: _____
Suicidal behavior	Yes: _____	No: _____
Suicidal ideation (e.g., fantasies, dreams, thoughts, premonitions, or fears relating to death, accident, or suicide)	Yes: _____	No: _____

2. Epilepsy and/or seizure disorder Yes: _____ No: _____

3. Alcoholism Yes: _____ No: _____

4. Drug Abuse Yes: _____ No: _____

If you answered yes to any of the above, for each condition, please describe your symptoms, the date you first experienced symptoms, the date you were diagnosed, the name and address of the physician(s) who diagnosed and/or treated you, the treatment you received, and the current status of the condition, to the extent not already answered in Section V.A above:

Condition / Symptoms	**When first experienced symptoms**	**When first diagnosed**	**Name(s) of health care provider(s) who treated and/or diagnosed**	**Treatment received (including medications, if any)**	**Do you suffer from this condition today (Y/N)?**

If you ever have attempted suicide in the past, please complete the following for each and every suicide attempt:

Date you attempted suicide	**Method by which you attempted suicide**	**Were any toxicology tests performed (Y/N)?**

C. Smoking History:

1. State amount smoked up until you began using Chantix:

Packs per Day	**Number of Years Smoked**	**Dates of Years You Smoked**

2. Has any doctor ever advised you that any health condition you had was caused or exacerbated by smoking? Yes: _____ No: _____

   If so, what health condition did your doctor tell you was caused or exacerbated by smoking?

   _____

   _____

3. Has any doctor ever advised you to quit smoking for health reasons?

   Yes: _____ No: _____ If so, what health reasons did your doctor give in advising you to quit smoking?

   _____

   _____

4. During the time that you were using Chantix, did you continue to smoke ?

   Yes: _____ No: _____ Do Not Recall: _____

If yes, state amount smoked: _____ packs per day from _____ to _____

If no, state date on which smoking ceased: _____

5. Did you smoke cigarettes on the day of your alleged injury?

Yes: ____ No: ____ Do Not Recall: _____

6. Indicate whether you have smoked cigarettes since you stopped using Chantix:

Yes: _____ No: _____ If yes, state amount smoked:

___ packs per day during the period _____ to _____

7. Had you ever tried to stop smoking before you used Chantix?

Yes: _____ No: _____ If yes, identify the date and duration of your quit attempt, the amount you smoked prior the quit attempt, how you tried to quit (*e.g.*, Zyban, nicotine gum, cold turkey, other), and why you resumed smoking:

Date and Duration of Quit Attempt	**Packs Smoked per Day in Month Leading up to Quit Attempt**	**Method of Quit Attempt**	**Reason(s) Why You Resumed Smoking**

D. Drinking History:

1. Do you currently or have you in the past drank alcohol (beer, wine, whiskey, etc.)? Yes: _____ No: _____

2. If yes, please check which represents your typical alcohol consumption in the six (6) months leading up the date on which you first experienced any symptoms you believe are related to the injury/ies alleged in your Complaint:

_____ 1 - 2 drinks per week
_____ 3 - 6 drinks per week
_____ 7 - 10 drinks per week
_____ 10 or more drinks per week
_____ Other (explain: _____)

3. If yes, please check which represents your typical alcohol consumption over the past ten (10) years:

_____ 1 - 2 drinks per week
_____ 3 - 6 drinks per week
_____ 7 - 10 drinks per week
_____ 10 or more drinks per week
_____ Other (explain: _____)

E. Illegal Drug Use:

1. At any time, have you ever been arrested for, charged with, tested positively for, and/or treated for use of an illegal drug of any kind (i.e., cocaine, ecstasy, heroin, marijuana, methamphetamines, etc.)? Yes ____ No _____

2. At any time, have you ever frequently used an illegal drug? Yes ____ No _____

3. Have you used any illegal drug more than ten times per year in any of the past fifteen (15) years? Yes ____ No _____

4. Since one year before you started taking Chantix to the present, have you used (even one time) any illegal drug? Yes ____ No _____

If you answered yes to any of the above questions, please: (1) identify each substance, (2) when you first and last used it, and (3) how frequently you used it.

_____

F. Family Medical History: Please indicate whether, to the best of your knowledge, your *parents, siblings, children,* or *grandparents* have experienced, been diagnosed with, or treated for any of the following conditions:

1. Mental health conditions, including but not limited to:

Aggressive/violent behavior	Yes: ___	No: ___	Don't Know: ___
Anxiety (on at least a periodic basis)	Yes: ___	No: ___	Don't Know: ___
Attention Deficit/Hyperactivity Disorder	Yes: ___	No: ___	Don't Know: ___
Bi-polar disorder	Yes: ___	No: ___	Don't Know: ___
Depression (on at least a periodic basis)	Yes: ___	No: ___	Don't Know: ___
Personality disorders	Yes: ___	No: ___	Don't Know: ___
Psychosis or psychiatric illnesses	Yes: ___	No: ___	Don't Know: ___
Schizophrenia	Yes: ___	No: ___	Don't Know: ___
Suicide attempt / completed suicide	Yes: ___	No: ___	Don't Know: ___
Suicidal behavior	Yes: ___	No: ___	Don't Know: ___
Suicidal ideation (e.g., fantasies, dreams, thoughts, premonitions, or fears relating to death, accident, or suicide)	Yes: ___	No: ___	Don't Know: ___

2. Epilepsy and/or seizure disorder Yes: ___ No: ___ Don't Know: ___

3. Alcoholism Yes: ___ No: ___ Don't Know: ___

4. Drug Abuse Yes: ___ No: ___ Don't Know: ___

If you answered yes to any of the preceding, please identify: (1) the person(s) who experienced, was diagnosed with, or was treated for that condition, (2) that person's relationship to you, (3) the condition that person experienced, and (4) whether that person died from the condition or complications related to the condition.

Person	**Relationship to You**	**Condition**	**Death from Condition?**

G. Medications: List all prescription medications you have taken in the past ten (10) years, including the name of the medication, the time period(s) you took it (including the dates first and last taken), and the reasons your physician prescribed it, if known:

Medication	**Date First Taken**	**Date Last Taken**	**Reason for Prescription/Use**

VI. DOCUMENTS

A. Authorizations: Please sign and attach to this Fact Sheet the authorizations for the release of records appended hereto.

B. Documents in your possession: If you have any of the following materials in your custody or possession, or in the possession, custody or control of your lawyers, please attach a copy to this Fact Sheet.

1. If you have been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding.

2. Copies of all medical records, bills, and any other documents from physicians, psychiatrists, healthcare providers (including mental health care providers), hospitals, pharmacies, insurance companies, or others who have provided treatment to you in the past ten (10) years or that you otherwise identified in this Fact Sheet, including but not limited to documents relating to your purchase of Chantix such as receipts, prescriptions, or records of purchase.

3. All documents constituting, reporting, summarizing, or referring to any medical test, psychological test, psychiatric test, or mental health test of any kind ever taken by or administered to plaintiff over the past ten (10) years.

4. All documents that describe, refer to, or record any conviction of plaintiff for a: (1) felony, (2) crime of dishonesty, (3) crime involving the use of, possession of, addiction to, intoxication with, or abuse of any form of alcohol, controlled substance, mind-altering substance, illegal drug, or medication, or (4) act of violence against or abuse of another person over the past ten (10) years.

5. All notes, reports, recommendations, memoranda, correspondence, and other documents in which any person, including, but not limited to, school administrators, counselors, health care providers, and/or law enforcement personnel, described, warned about, opined on, or in any way referred to any actual, observed, or possible behavioral problem, deportment problem, psychological or psychiatric problem, mental problem, mental illness, alcohol problem, suicidal ideation, or substance-abuse problem of or with respect to plaintiff for a period of ten (10) years prior to the date of the alleged injury.

6. All documents constituting, concerning, or relating to product use instructions, product warnings, package inserts, pharmacy handouts, or other materials distributed with or provided to you in connection with your use of Chantix, including but not limited to documents which mention Chantix or any alleged health risks or hazards related to Chantix in your possession at or before the time of the injury alleged in your Complaint.

7. Copies of advertisements, brochures, pamphlets, web pages, or other promotional material for Chantix, as well as any other documents related to Chantix.

8. Any articles, web pages, books, or other documents discussing smoking and/or smoking cessation.

9. Copies of the entire packaging, including the bottle, box and label for the Chantix you allege caused you injury and any remaining medication. (To the extent these items already are in your possession, you or your attorney must maintain the originals of the items requested in this subpart.)

10. Copies of any document written or prepared by plaintiff, including but not limited to any journal(s), diary(ies), note(s), letter(s), and/or email(s), that mentions, discusses, or refers to any thought, expression, or act of suicide, depression, anxiety, grief, hostility, troubled behavior, or violence, including, but not limited to, any suicide note(s) and/or letters, emails, or other communications around the time of the incident or at any other time, or that refers to any injuries or illnesses you allege were caused by Chantix.

11. Copies of all documents you (not your lawyer) obtained from any source related to Chantix or to the alleged effects of ingesting Chantix, including but not limited to documents obtained directly or indirectly from Pfizer.

12. All documents relating to any web sites you have viewed, chat rooms, web logs (or "blogs"), electronic mail, or other Internet activity in which you have engaged related to your use of Chantix, smoking cessation, and/or the injuries you allege Chantix caused.

13. All documents relating to any communication by any person, including your attorneys, to or from the Food & Drug Administration ("FDA"), including but not limited to on-line, telephoned, mailed, or faxed communications to the FDA's MedWatch program regarding Chantix, including the dates of such communications.

14. If you claim you have suffered a loss of earnings or earning capacity, your W-2s for each of the last five (5) years.

15. Copies of letters testamentary or letters of administration relating to your status as plaintiff (if applicable).

16. Decedent's death certificate and autopsy report (if applicable).

VERIFICATION

I declare under penalty of perjury subject to 28 U.S.C. § 1746 that all of the information provided in this Plaintiff's Fact Sheet is true, complete, and correct to the best of my knowledge, information, and belief, and that I have supplied all the documents requested in Part VI of this Plaintiff's Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have signed and supplied the authorizations attached to this Verification.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in any material respect incomplete or incorrect.

_____ _____

Signature Date

Print Name: _____