DES QUESTIONNAIRE

PERSONAL DATA:

1. NAME:
2. ANY OTHER NAME USED (include dates when used):
3. YOUR DATE OF BIRTH:
4. PLACE OF BIRTH: (Hospital, City and State)
5. SOCIAL SECURITY NO.:
6. CURRENT ADDRESS: E-MAIL ADDRESS:
7. TELEPHONE NUMBERS: (H): (W):
8. OCCUPATION:
9. SPOUSE'S NAME: SOCIAL SECURITY NO.:
10. DATE OF BIRTH: PLACE OF BIRTH:
11. OCCUPATION:
12. DATE(S) MARRIED: (list names of all spouses and dates of marriage for both of you)

INJURIES/DAMAGES:

13. TOTAL NUMBER OF PREGNANCIES: (Date and Outcome of each pregnancy)

    LIVE BIRTHS: (Date and child's name)

    MISCARRIAGES: (Date of each, how far along were you)

    ECTOPIC PREGNANCIES: (Date of each, Treatment/Procedure)

    ABORTIONS: (Date of each)

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14. YOUR KNOWN PHYSICAL DES-RELATED INJURIES:

Anatomical Injury	Date Diagnosed	Name of Doctor	Address of Doctor

15. IF THE INJURY IN QUESTION IS PREMATURE DELIVERY, WHAT DID YOUR DOCTOR ATTRIBUTE THE PREMATURITY TO?

16. DESCRIBE ANY CONDITIONS YOUR CHILD HAS SUFFERED AS A RESULT OF PREMATURE BIRTH.

17. YOUR CHILD'S PHYSICIANS: (Name and Address of Pediatricians and any Specialists.)

18. GIVE YOUR BEST ESTIMATE OF EXPENSES INCURRED TO DATE: (e.g., hospital bills, surgical bills)

19. HAVE YOU ADOPTED OR ARE YOU PRESENTLY ADOPTING: (If yes, list the date of adoption, adoption agency or referral source, etc.)

YOUR MEDICAL HISTORY:

20. DATE OF MOST RECENT GYNECOLOGICAL EXAM:

21. HAVE YOU EVER UNDERGONE AN HSG (HYSTEROSALPINGOGRAM)? i.e., a procedure where dye is injected through the cervix into the uterus and tubes to look for abnormalities of those organs. If so, please give us the **name of the doctor, the date of the test and where the test was done**.

Date	Name of Doctor	Hospital/Clinic Address

22. LIST ANY INFERTILITY SPECIALIST CONSULTED: (Date(s), Name, Address, Telephone)

23. BIRTH CONTROL HISTORY: list all methods of birth control and the dates they were used.

24. PLEASE LIST ALL OB-GYN PHYSICIANS SEEN FROM YOUR FIRST EXAM TO PRESENT: (Include health clinics and university clinics)

Dates Seen	Name	Address	Treatment/Procedures/Surgeries

25. OTHER RELEVANT MEDICAL HISTORY, ILLNESS, SURGERIES: (Include any psychiatric care or counseling you have received due to your DES injury.)

Date	Physician/Hospital address	Treatment

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DES EXPOSURE INFORMATION:

26. WHEN DID YOU FIRST BECOME AWARE OF YOUR DES EXPOSURE?

27. HOW DID YOU BECOME AWARE OF YOUR DES EXPOSURE?

28. WHEN DID YOU FIRST LEARN THAT YOU COULD BRING SUIT AGAINST A PHARMACEUTICAL COMPANY? (list any previous attorney(s) seen and date consulted)

29. HOW DID YOU LEARN THAT YOU COULD BRING SUIT AGAINST A PHARMACEUTICAL COMPANY?

30. WHO REFERRED YOU TO PATRICIA M. STANFORD?

FAMILY HISTORY:

31. MOTHER'S NAME: (Including maiden name)

32. MOTHER'S DATE OF BIRTH: SOCIAL SECURITY NO.:

33. MOTHER'S CURRENT ADDRESS:

34. MOTHER'S TELEPHONE NUMBER: (H): (W):

35. YOUR MOTHER'S ADDRESS DURING HER PREGNANCY WITH YOU:

36. ANY OTHER NAME YOUR MOTHER USED DURING HER PREGNANCY WITH YOU:

37. FATHER'S NAME: SOCIAL SECURITY NO.:

38. FATHER'S CURRENT ADDRESS:

39. FATHER'S TELEPHONE NUMBERS: (H): (W):

40. YOUR SIBLINGS:

Name	Date of Birth	Exposed to DES (Y/N)	No. of Pregnancies/No. of Children

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INFORMATION ON DES DOSAGE:

41. PLEASE GIVE DETAILS OF YOUR MOTHER'S RECOLLECTION OF MEDICATION(S) INGESTED DURING PREGNANCY WITH YOU:

Name of Medication	Dosage	Color and Size of Tablet	Period of Time Taken (Mo/Yr started to Mo/Yr stopped)	Where Taken (Home, Hospital, Doctor's office)

42. REASON MOTHER WAS GIVEN DES:

43. MOTHER'S PREGNANCY HISTORY: (Date, Outcome of each pregnancy, Doctor's Name)

44. IF MOTHER IS DECEASED, IS THERE ANY OTHER FAMILY MEMBER (i.e., husband, sister, etc.) WHO MAY RECALL ANYTHING ABOUT THE PRESCRIPTION OR THE ACTUAL MEDICATION INGESTED? If so, list Name, Address, Telephone Number, Relationship.

45. MOTHER'S PRESCRIBING PHYSICIAN: (**Full Name**, Last Address, Telephone Number, whether doctor is deceased).

46. PHARMACY(IES) WHERE PRESCRIPTION FOR **DES** WAS FILLED. (Name of Pharmacist, Name of Store, and Address.) If unknown, pharmacies your mother may have used.

47. OTHER PHYSICIANS YOUR MOTHER CONSULTED DURING HER PREGNANCY WITH YOU: (Name, Address, Reason.)

48. HOSPITALS OR OTHER MEDICAL FACILITIES AT WHICH YOUR MOTHER WAS TREATED DURING HER PREGNANCY WITH YOU: (Name, Address, Reason for hospitalization.)

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