DATABASE INFORMATION FORM

NAME:

ADDRESS:

PHONE NO.: (Home)

(Work)

FAX NO.:

EMAIL:

ALTERNATE CONTACT PERSON: (Name, Address and Phone Number)

DATE OF BIRTH:

HEALTH CARD NO.:

FAMILY DETAILS:
(ex. married, single, children, etc.)

FAMILY MEDICAL HISTORY:

DATE STARTED TAKING ZYPREXA:

DOSAGE PRESCRIBED:
Did you take the prescibed dosage?
If not, what dosage were you taking?

REASON FOR TAKING ZYPREXA:

DATE STOPPED TAKING ZYPREXA:

LIST OF ANY OTHER PRESCRIPTION DRUGS TAKEN: (either before or during your Zyprexa usage)

PRE-EXISTING MEDICAL/HEALTH CONDITION:
(prior to starting Zyprexa, please include information such as cholesterol or high blood pressure)

ANY KNOWN MEDICAL CONSEQUENCES:
(after taking Zyprexa)

_____ DIABETES

_____ HYPERGLYCEMIA

_____ PANCREATITIS

____ METABOLIC ACIDOSIS

_____ KETOACIDOSIS

_____ BLOOD SUGAR DISORDERS

_____ DYSLIPIDEMIA

_____ DEATH

______OTHER

COMMENTS:
(please identify symptoms experienced and provide the dates when these symptoms occurred)

TREATMENT GIVEN:
(include dates of any hospitalizations)

FAMILY PHYSICIAN:
(include name and address)

ANY OTHER PHYSICIANS WHO PRESCRIBED ZYPREXA TO YOU:
(include names and addresses)

PHARMACIES WHERE YOUR ZYPREXA PRESCRIPTION WAS FILLED:
(include names and addresses)

ARE YOU OR HAVE YOU EVER BEEN A SMOKER?

ARE YOU PREPARED TO BE A PLAINTIFF?

Please complete and remit to:

Lauren Black
Stevensons LLP
Barristers
144 Front Street West
Suite 400
Toronto, Ontario
M5J 2L7

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416-599-7910 (fax)
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