

CONFIDENTIAL



CRESTOR QUESTIONNAIRE

# CRESTOR QUESTIONNAIRE

PLEASE RETURN TO

FONVIELLE LEWIS FOOTE & MESSER  
3375 CAPITAL CIRCLE N.E.  
BUILDING A  
TALLAHASSEE, FLORIDA 32308  
800-876-7773  
(850) 422-7773  
FAX: (850) 422-3449

DATE: \_\_\_\_\_

## GENERAL INFORMATION

1. Injured person: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_
- Telephone: H: \_\_\_\_\_ W: \_\_\_\_\_
- Mobile Telephone or e-mail address: \_\_\_\_\_
- Birthdate: \_\_\_\_\_ Date of Death: \_\_\_\_\_
- Social Security No.: \_\_\_\_\_
- Marital Status \_\_\_\_\_ Spouse's name \_\_\_\_\_
- Spouse's Date of Birth: \_\_\_\_\_ Social Security No. \_\_\_\_\_

NOTE: If you are completing this form for a friend or family member, please provide the following information:

Name and relationship to injured person:

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: H: \_\_\_\_\_ W: \_\_\_\_\_

## INFORMATION CONCERNING CRESTOR USE

2. Who prescribed your Crestor? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Reason for its use? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Date first taken? \_\_\_\_\_
5. Date stopped? \_\_\_\_\_
6. Reason you stopped? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Please list the dosage you took?  
(including any restart dates) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Did you receive a recall letter from your physician or pharmacist? \_\_\_\_\_
9. Do you still have receipts for your purchases of Crestor, a pill bottle  
or any remaining pills? \_\_\_\_\_

Be sure to keep all containers and pills in a safe place until you turn them over to us.

**DO NOT RETURN PILLS OR BOTTLES TO THE PHARMACY  
OR DRUG COMPANY.**

10. Please list any other brands of statins (cholesterol lowering medications) you have  
taken and the dates of you took them:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. When were you diagnosed with Rhabdomyolysis?  
Date diagnosed: \_\_\_\_\_

12. Physician or medical provider that made the diagnosis:  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_

13. If the diagnosis was made at a hospital or clinic, please provide:  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_

14. Do you have copies of any of the bloodwork or lab reports? \_\_\_\_\_

15. Where was the bloodwork or testing performed?  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_

16. Please list the names and addresses of each pharmacy where you purchased Crestor.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

17. What are your current symptoms and for each symptom, please list the date it first appeared?

18. Have you sought medical treatment for these symptoms? If so, please list the names and addresses for each physician and note the specialty area of practice for each physician (for example: cardiologist, rheumatologist, etc.).

Name: _____	Specialty area: _____
Address: _____	Treated for: _____
_____	_____
Telephone: _____	Dates of Treatment: _____

Name: _____	Specialty area: _____
Address: _____	Treated for: _____
_____	_____
Telephone: _____	Dates of Treatment: _____

Name: _____	Specialty area: _____
Address: _____	Treated for: _____
_____	_____
Telephone: _____	Dates of Treatment: _____

19. Have you been hospitalized at any time for these symptoms? If so, please provide:

Hospital: _____	Admitted for: _____
Address: _____	_____
_____	_____
Telephone: _____	Date of Treatment: _____

Hospital: _____	Admitted for: _____
Address: _____	_____
_____	_____
Telephone: _____	Date of Treatment: _____

20. Have you undergone any recent medical testing such as blood work, liver profiles or dialysis? If so, when and where?

21. Please provide a detailed medical history, including any and all illnesses or diseases.





24. How tall are you? \_\_\_\_\_
25. What was your approximate weight when you began taking Crestor? \_\_\_\_\_
26. Have you had any reactions or been hypersensitive to any other statin or cholesterol lowering medication? \_\_\_\_\_
27. Do you have a history of liver problems or disease? \_\_\_\_\_  
Have you ever been told you have hematuria or blood in your urine? \_\_\_\_\_
28. Do you have a history of renal (kidney) problems or disease? \_\_\_\_\_
29. Have you ever been told you have proteinuria, albuminuria or protein in your urine? \_\_\_\_\_
30. While taking Crestor did you experience muscle pain, weakness or muscle cramping? \_\_\_\_\_
31. Have you been diagnosed with myopathy, myositis or myalgia (any pain or disease of the muscles)? \_\_\_\_\_
32. Have you been diagnosed with cancer, leukemia, rheumatoid arthritis, lupus erythematosus, mycosis fungoides or vasculitis? \_\_\_\_\_
33. While taking Crestor, did you take cyclosporine (Cytoxin or cyclophosphamide)? \_\_\_\_\_
34. Have you ever been diagnosed with hypothyroidism? \_\_\_\_\_
35. Have you or any members of your family been diagnosed with hereditary muscular disorders: \_\_\_\_\_
36. Have you been previously diagnosed with muscle toxicity? \_\_\_\_\_
37. Have you ever been diagnosed with alcohol abuse? \_\_\_\_\_
38. Are you of Japanese or Chinese descent? \_\_\_\_\_
39. While taking Crestor, did you also take Gemfibrozil or Lopid or another medication to lower triglyceride levels? \_\_\_\_\_
40. Were you provided any information concerning Crestor? For example, pamphlets, testing procedures, adverse effects, etc \_\_\_\_\_
41. What did your physician tell you about Crestor? \_\_\_\_\_

42. Have you been contacted by any federal, state or local health agencies concerning your Crestor usage? \_\_\_\_\_

43. Have the manufacturers, distributors or pharmacies contacted you concerning Crestor? If so, when? Do you have copies of any correspondence? \_\_\_\_\_

44. Have any of your physicians informed you that your problems are a result of ingesting Cestor? \_\_\_\_\_

If yes, please explain:

45. Have any of your bills been paid in whole or in part by insurance? \_\_\_\_\_

If yes, in the space provided please list the names and addresses of your insurance carrier(s):