

BLACKWELL PLAINTIFF'S FACT SHEET

(please attach additional pages where necessary)

I. PERSONAL DATA

A. Clients' Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Year home was built: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Your Date of Birth: _____

Your Social Security Number: _____

Married: Yes ___ No ___

If yes, please provide the following information:

Spouse's Full Name: _____

Spouse's Date of Birth: _____

Spouse's Social Security Number: _____

Date and Place of Marriage: _____

Does your spouse plan to file a loss of consortium claim? Yes ___ No ___

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

1. Your Name: _____

2. Street Address: _____

3. Capacity in which you are representing the individual: _____

4. Your relationship to the deceased or represented person: _____

5. If you represent a decedent's estate, state the date of death of the decedent and attach copies of all court documents appointing you as representative of the estate including a copy of any will.

(if you are filling out this questionnaire on behalf of yourself and you have also filled out Section I.B. for a deceased person or a minor, please fill out an additional questionnaire for all deceased persons or minors; you need only fill out the following sections of each additional person – Sections I., III., VIII., IX., and X.)

II. CHILDREN

Children: Yes _____ No _____

If yes, please provide the following information:

1. Child's Name: _____

Address: _____

Date of Birth: _____ Dependent on you? Yes ___ No ___

If yes, social security number: _____

2. Child's Name: _____

Address: _____

Date of Birth: _____ Dependent on you? Yes ___ No ___

If yes, social security number: _____

3. Child's Name: _____

Address: _____

Date of Birth: _____ Dependent on you? Yes ___ No ___

If yes, social security number: _____

4. Child's Name: _____

Address: _____

Date of Birth: _____ Dependent on you? Yes ___ No ___

If yes, social security number: _____

Name any other dependents other than spouse and children, including date of birth and social security number: _____

III. EDUCATION

School Name	City, State	Years Attended

IV. PRIOR CLAIMS HISTORY

Have you ever been involved in any claim for damages in any type of litigation?

Yes ___ No ___ If yes, please provide the following information:

Nature and reason for case: _____

Outcome: _____

V. FAMILY HISTORY

Father:

Name: _____

Date of Birth: _____ Date of Death (If applicable): _____

Cause of Death (If applicable): _____

Mother:

Name: _____

Date of Birth: _____ Date of Death (If applicable): _____

Cause of Death (If applicable): _____

Siblings:

Name: _____

Date of Birth: _____ Date of Death (If applicable): _____

Cause of Death (If applicable): _____

Name: _____
Date of Birth: _____ Date of Death (If applicable): _____
Cause of Death (If applicable): _____

Name: _____
Date of Birth: _____ Date of Death (If applicable): _____
Cause of Death (If applicable): _____

VI: MISCELLANEOUS INFORMATION

1. Have you ever served in any branch of the U.S. Military? Yes _____ No _____

If yes, please state:

- a. Branch, dates of service and type of discharge. _____
b. Were you discharged for any reason relating to your health or physical condition?
Yes _____ No _____

If yes, state what that condition was. _____

- c. Have you ever been rejected from military service for any reasons relating to your health or physical condition? Yes _____ No _____

If yes, state what the condition was. _____

2. Have you ever filed a worker's compensation claim? Yes _____ No _____

If yes, please state:

1. Year claim was filed: _____

2. Where claim was filed: _____

3. Claim/docket number, if applicable: _____

4. Nature of disability: _____

5. Period of disability: _____

6. Name and address of all health care providers treating you for each Worker's

Compensation claim: _____

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

3. Have you ever filed a social security disability claim? Yes _____ No _____

If yes, please state:

1. Year claim was filed: _____
2. Where claim was filed: _____
3. Claim/docket number, if applicable: _____
4. Nature of disability: _____
5. Period of disability: _____
6. Name and address of all health care providers treating you for each Worker's Compensation claim: _____

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

4. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury or health related condition? Yes _____ No _____

If so, state the court in which such action was filed and the civil action or docket number assigned to each such claim, action or suit. If no court action then provides the name of each person, entity or insurance company with whom a claim was made and the nature of the claim.

VII: EMPLOYMENT HISTORY

1. Complete the following information with respect to your employment for the past thirty years.

Employers for Past 30 Years	Address	Type of Business/Position	Dates of Employment

2. State your earned income for each of the last five (5) years.

Year	Income
2005	\$
2004	\$
2003	\$
2002	\$
2001	\$

3. Was any member of your family ever employed by Blackwell Zinc Company in Blackwell Oklahoma? If so please list their names, dates of employment and date of death, if applicable:

1. _____
2. _____
3. _____

VIII. RESIDENCY INFORMATION

1. How long have you lived at your current address? _____
2. Do you own or rent your residence? _____
3. How much is your monthly rental or mortgage payment? _____

4. Please list all prior residences below (please list as many as you can from your date of birth to present):

Street Address	City, State, Zip	Years Occupied	Other Individuals Living at this Address

IX. PERSONAL HEALTH HISTORY

1. Have you ever smoked cigarettes? Yes ___ No ___
If yes, when, how often and for how long? _____
2. Do you currently smoke cigarettes? Yes ___ No ___
3. Have you been diagnosed with any condition that is caused by smoking?
Yes ___ No ___
If yes, what is the condition? _____

4. Health Problems (Check all that apply):

abdominal pain and cramping	diarrhea	irritability	persistent, unexplained fatigue
abnormal heart rhythm	difficulty sleeping	kidney problems	poor coordination
aggressive behavior	easy bruising	learning disabilities	premature birth
anemia	edema	liver injury (jaundice)	proteinuria
behavior or attention problems	encephalopathy	loss of appetite	seizures or coma
bladder cancer	hair loss	loss of previous developmental skills	slow reflexes
brittle nails with Mee's lines	headaches	low appetite and energy	skin cancer
changes in mood or personality	hearing problems	low birth weight	skin discoloration (spotty)
changes in sleep patterns	high rate of tooth decay	lung cancer	skin thickening
chronic obstructive pulmonary disease	hyperactivity	memory problems	staggering gait
colon cancer	hyperkeratosis	miscarriages	testicular cancer
constipation	hypertension	muscle weakness	warty growths
decreased activity and fatigue	immunosuppression	peripheral neuropathy	
decreased bone density	inability to concentrate	"pins and needles" sensations	
decreased sex drive	increased sleeping	polyneuropathy	

Definitions

Anemia - Most commonly, people with anemia report a feeling of weakness or fatigue, general malaise (a general state of discomfort, tiredness, or illness) and sometimes a poor concentration. People with more severe anemia sometimes report shortness of breath. Very severe anemia prompts the body to compensate by increasing cardiac output, leading to palpitations and sweatiness, and to heart failure. Pallor (pale skin, mucosal linings and nail beds) is often a useful diagnostic sign in moderate or severe anemia, but it is not always apparent.

Brittle nails with Mee's lines - are horizontal lines of discoloration which occur on the nails of the fingers and toes after an episode of exposure to arsenic or thallium or other heavy metals. They are typically white bands traversing the width of the nail. With growth of the nail, they are displaced upward on the nail and eventually disappear when trimmed.

COPD - (chronic obstructive pulmonary disease) is an umbrella term for a group of respiratory diseases that are characterized by airflow obstruction or limitation. The most common cause is smoking, but **COPD** can also be caused by exposure to other airway irritants like coal dust or solvents.

Edema - is the increase of fluid in any organ. Also called peripheral or dependent edema, it is the accumulation of fluid in the parts of the body that are most affected by gravity. In ambulatory people these are the legs, although in those who are bedbound the first manifestation may be in the sacral region of the lower back.

Encephalopathy - means disease of the brain. It refers to the central nervous system, or parts of it. The hallmark of encephalopathy is an altered mental state. Depending on the type and severity of encephalopathy, common neurological symptoms are progressive loss of memory and cognitive ability, subtle personality changes, inability to concentrate, lethargy, and progressive loss of consciousness.

Hyperkeratosis - results when an excess of proteins called keratins are produced. In humans, the term typically refers to a thickening of the skin.

Hypertension - high blood pressure

Peripheral neuropathy - is the medical term for damage to nerves of the peripheral nervous system, which may be caused either by diseases of the nerve or from the side-effects of systemic illness. In terms of sensory function, there are commonly loss of function (negative) symptoms, which include numbness, tremor and gait imbalance. Gain of function (positive) symptoms include tingling, pain, itching, crawling skin and pins and needles. Motor symptoms include loss of function (negative) symptoms of weakness, tiredness, heaviness, and gait abnormalities; and gain of function (positive) symptoms of cramps and muscle tremor.

Polyneuropathy - is another neurological disorder that occurs when many peripheral nerves throughout the body malfunction simultaneously. It may be acute and appear without warning, or chronic and develop gradually over a longer period of time. Many polyneuropathies have both motor and sensory involvement as described above. These disorders are often symmetric and frequently involve distal extremities.

Proteinuria - means the presence of an excess of serum proteins in the urine. The protein in the urine often causes the urine to become foamy. Proteinuria may be a sign of renal (kidney) damage.

5. For any other health problems not specifically listed above, please describe in detail below:

X. TREATING PHYSICIANS

Please provide the name of any and all physicians or facilities that have treated you during the last ten years. Please include your primary care physician, internist, cardiologist, vascular surgeon, pulmonologist, neurologist, neurosurgeon, psychologist, psychiatrist, social worker, etc. Please use the back of this paper or additional paper if more space is needed.

Physician Name _____ Specialty _____
Street Address _____
City, State, Zip Code _____
Phone Number _____
Reason For Treatment _____
Dates of Treatment _____

Physician Name _____ Specialty _____
Street Address _____
City, State, Zip Code _____
Phone Number _____
Reason For Treatment _____
Dates of Treatment _____

Physician Name _____ Specialty _____
Street Address _____
City, State, Zip Code _____
Phone Number _____
Reason For Treatment _____
Dates of Treatment _____

Physician Name _____ Specialty _____
Street Address _____
City, State, Zip Code _____
Phone Number _____
Reason For Treatment _____
Dates of Treatment _____

XI. MISCELLANEOUS INFORMATION:

1. Health Insurance:

Do you have full health insurance coverage? Yes ___ No ___

If yes, what percentage of your medical benefits are paid by insurance?
_____ %

Name of insurance carrier: _____

Address: _____

Phone Number: _____

Primary Policyholder: _____

Policy Number: _____

Date you started with this insurance carrier: _____

Prior insurance carrier names, addresses and dates with this carrier and policy or group numbers: _____

2. Medicare

Do you currently have Medicare? Yes ___ No ___

If yes, date started: _____

Medicare Number: _____

3. Medicaid

Have you ever been on Medicaid? Yes ___ No ___

If yes, date started and date stopped: _____

Medicaid number and appropriate state _____

XII. DOCUMENTS

Attach the following documents to this declaration, to the extent that such documents are currently in your possession (if either the documents or an executed authorization to obtain such documents have not been previously supplied).

- A. Executed authorizations permitting release of records from all doctors and pharmacies.
- B. If you claim you have suffered a loss of earnings or earning capacity, your W-2 and/or 1099 income tax forms for each of the last five (5) years.
- C. If you claim any loss for medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider.

COMPLETED THIS _____ DAY OF _____.

I certify that the preceding information, and any additional information attached hereto, is true and correct to the best of my knowledge and belief.

SIGNATURE