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.

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____

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.

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SIGNATURE