

THE LAW OFFICES OF
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Prempro/Premarin/Premphase Initial Intake Questionnaire

DATE:			
NAME:			
Relationship to User: (Self, Mother, Daughter, etc.)			
ADDRESS:	Street:		
	City:	State:	Zip:
E-MAIL ADDRESS:			
PHONE:	Home:	Work:	Cellular:
SOCIAL SECURITY NO:			Date of Birth:
NAME, ADDRESS AND TELEPHONE NUMBER OF A RELATIVE OR FRIEND WHO WILL ALWAYS KNOW YOUR WHEREABOUTS:			
Please answer the following questions related to Prempro/Premarin/Premphase/Other:			
1.	Which drug did you take, Prempro, Premarin and/or Premphase?		
2.	Date you began taking Prempro/Premarin/Premphase?		
3.	Are you currently taking Prempro/Premarin/Premphase?		
4.	If not, date you stopped taking Prempro/Premarin/Premphase?		

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5.	When you were taking Prempro/Premarin/Premphase, how often (daily, weekly, monthly, etc.) did you take the drug?
6.	What was the dosage (mg) of Prempro/Premarin/Premphase you were prescribed? (PLEASE BE SPECIFIC; OBTAIN PHARMACY RECORDS IF NECESSARY)
7.	Why were you prescribed Prempro/Premarin/Premphase?
8.	Did your doctor notify you of any warnings or side effects? If so, when were you notified, prior to taking, while taking or after taking the drug?
9.	Did the pharmacist notify you of any warnings or side effects? If so, when were you notified, prior to taking, while taking or after taking?
10.	When and how did you first become aware that you might have medical problems related to Prempro/Premarin/Premphase?
11.	Please identify the current symptoms/signs you have experienced since you began using Prempro/Premarin/Premphase by marking ("Y") for Yes and ("N") for No (Specify all that apply):

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11.	Breast Cancer:		(Please provide a copy of your pathology report)
	Lobular Breast Cancer:		
	Ductal Breast Cancer:		
	Heart Attack:		
	Stroke:		
	Venous Blood Clots (Pulmonary Embolism, Deep Vein Thrombosis):		
	Auto-Immune Diseases (Lupus, Scleroderma, Raynaud's, etc.):		
	Ovarian Cancer:		
	Gallbladder Cancer:		
	Coronary Heart Disease:		
	Alzheimer's Disease/Dementia:		
	Asthma:		
	Liver disease:		
	Other (Describe):		
12.	Do you have a confirmed diagnosis of any of the above?		
13.	If so, please specify the diagnosis and date you were diagnosed?		
	Diagnosis:		
	Date of Diagnosis:		
14.	If so, please provide the diagnosing physician's name, address and telephone number:		

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15.	Please describe your general current medical condition:
16.	Have your health problems been resolved or do they seem permanent?
17.	Do you feel that you were injured as a result of your use of Prempro/Premarin?
18.	Do you have health insurance?
19.	If so, please complete the following:
	Insurance Name: _____
	Policy Number: _____
	Primary Care Physician: _____
20.	Have you ever smoked? If so for how long and how much?
21.	Additional comments:
22.	How did you hear of us? (Omaha World Herald, Lincoln Journal Star, Fremont Tribune, Internet, TV, Referral, Other)

THANK YOU FOR COMPLETING THIS INITIAL QUESTIONNAIRE. PLEASE MAIL YOUR QUESTIONNAIRE TO OUR ADDRESS LISTED ABOVE AT YOUR EARLIEST CONVENIENCE AND WE WILL FOLLOW-UP WITH YOU IN DUE COURSE.