



Paraquat Questionnaire No. 1 – MEDICAL INFORMATION

Now that you have hired us to pursue your potential claim, it is time for us to get to work! Our first step requires us to investigate your injuries. For that, we need access to your medical records to prove you were either diagnosed with Parkinson's disease OR that you have been treated and/or diagnosed with some symptoms associated with Parkinson's disease. Because your claim is subject to a statute of limitations that sets a deadline for us to file your lawsuit and because we cannot file your lawsuit until we have your injury records, we request that you help us help you by doing the following things as soon as possible.

Importantly, we understand that the injuries associated with this claim may make it difficult to respond (either now or in the future), so please let us know if there is a loved one we should be corresponding with directly as well as with you:

1. **Send to us all medical records in your possession.** Please e-mail copies to: Marlena.stogsdill@AndrusWagstaff.com or mail a hard copy to Wagstaff Law Firm, c/o Marlena Stogsdill, 940 North Lincoln, Denver 80203.
2. **Sign the Consent to Access On-Line Medical Portal.** Sometimes, especially during COVID, it can take months to get the hospital or health care provider to send us your medical records. Meanwhile, while we wait, the same records we are requesting are often immediately available (usually free of charge) on your healthcare provider's on-line portal. If you execute this consent, we can quickly access your medical records.
3. **Sign the HIPAA documents.** This allows us to send medical releases to your medical providers. Of course, for us to know where to send the HIPAA release requests, you must complete No. 4 (below) as accurately as possible.
4. **Complete the questions below as soon as possible.** If you do not have the medical records in your possession, and we cannot access them online, we will need to send requests to your providers. Gathering medical records can take months to complete, so it is important we start as soon as possible. Similarly, it is very important you provide us with the most accurate information you can so we can make sure we get the correct information on the first try. It is very important that you try and get the date ranges for treatment as accurate as possible.

You will receive another questionnaire later that will ask for information related to your Paraquat exposure, family medical history, work history, and other information. **However, because we need certain medical information in order to file your case, we wanted to send the enclosed questionnaire to you right away.**

Please do not delay in submitting your responses. Please contact us with any questions.

1. Injured Party Information

Injured Party's Name: Don Sargent

Other Names Used (e.g., maiden): N/A

Date of Birth: 08/26/1950 Social Security Number: 330480187

2. Parkinson's Diagnosis information

Were you or your loved one was diagnosed with Parkinson's disease? Yes

What was the date you or your loved one was diagnosed with Parkinson's disease? (month/year) 2010

(If not diagnosed with Parkinson's, skip to Question 4 below.)

3. Identity of doctor(s) who diagnosed you or your loved one with Parkinson's disease:

Diagnosing Physician Name: Dr Thiha

Date range treatment rendered (month/year): August 2010

Facility Name: Board certified in Internal Medicine

Specialty: On medication Phone #: 3214522016 Fax #: 3214525728

Address: 45 McLeod street Merritt Island Fl. 32953

4. Have you or your loved one, suffered any of the following symptoms after exposure to Paraquat or Gramoxone? If so, please check box.

<u>Diagnosis/Symptom</u>	<u>Date of Symptom Onset</u> <u>(best approximation, month/year)</u>
a. <input type="checkbox"/> Tremors (hand or other)	_____
b. <input type="checkbox"/> Prolonged or extreme stiffness	2010
c. <input checked="" type="checkbox"/> Difficulty with body movements	2010
d. <input type="checkbox"/> Loss of balance	2010
e. <input type="checkbox"/> Difficulty walking (slow gait, shuffling)	2010
f. <input checked="" type="checkbox"/> Difficulty or soft speaking	2018
g. <input type="checkbox"/> Reduced facial expression, blank stare	_____
h. <input type="checkbox"/> Drooling	_____
i. <input type="checkbox"/> Small handwriting	_____
j. <input checked="" type="checkbox"/> Trembling	2013
k. <input checked="" type="checkbox"/> Whole body fatigue or dizziness	2013
l. <input type="checkbox"/> Amnesia or confusion in evening hours	2020
m. <input type="checkbox"/> Early awakenings or sleep disturbances	2011
n. <input type="checkbox"/> Anxiety or apathy	2010
o. <input type="checkbox"/> Hallucinations	_____
p. <input type="checkbox"/> Delusions	_____

5. Identity of doctor(s) who diagnosed/treated any condition(s) marked “yes” above:

Name of Neurologist or Movement Disorder Specialist (if applicable): Dr Thiha

Date range treatment rendered (month/year): 2010 until now

Facility Name: _____

Specialty: NA Phone #: 3214522016 Fax #: 3214525728

Address: 45 McLeod street Merritt Island Fl. 32953

Other Physician Name: _____

Date range treatment rendered (month/year): 2010 until now

Facility Name: board certified Internal Medicine

Specialty: NA Phone #: NA Fax #: NA

Address: NA

Other Physician Name: NA

Date range treatment rendered (month/year): NA

Facility Name: NA

Specialty: NA Phone #: NA Fax #: NA

Address: NA

Other Physician Name: NA

Date range treatment rendered (month/year): NA

Facility Name: NA

Specialty: NA Phone #: NA Fax #: NA

Address: NA

6. Identity of the hospital(s) or medical facilities that have rendered treatment for Parkinson's disease or symptoms:

Hospital Name: NA Phone #: NA Fax #: NA

Address: NA

Date range treatment rendered (month/year): NA

Hospital Name: NA Phone #: NA Fax #: NA

Address: NA

Date range treatment rendered (month/year): NA

7. Have you taken medication for Parkinson's or Parkinson's symptoms? Yes

8. Pharmacy that fills and/or has filled prescriptions for the injured person:

Pharmacy Name: Cocoa Beach discount Phone #: Na Fax #: Na

Address: Cocoa Beach Florida I don't know the ZIP code I don't know the street address

Pharmacy Name: _____ Phone #: _____ Fax #: _____

Address: _____