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: valcoour carroll jr

Other Names Used (e.g., maiden): _____

Date of Birth: 09/12/1948 Social Security Number: 000000000

2. Parkinson's Diagnosis information

Were you or 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) 12/2015

(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. Kooman

Date range treatment rendered (month/year): 12/2015

Facility Name: Kaiser

Specialty: Neurology Phone #: 9166882000 Fax #: _____

Address: 6600 Bruceville Road Sacramento, ca 95823

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

Diagnosis/Symptom	Date of Symptom Onset (best approximation, month/year)
a. ☑ Tremors (hand or other)	02/2008
b. ☑ Prolonged or extreme stiffness	02/2013
c. ☑ Difficulty with body movements	02/2013
d. ☑ Loss of balance	02/201
e. ☑ Difficulty walking (slow gait, shuffling)	02/2013
f. ☐ Difficulty or soft speaking	
g. ☐ Reduced facial expression, blank stare	
h. ☐ Drooling	
i. ☑ Small handwriting	02/2013
j. ☑ Trembling	02/2013
k. ☑ Whole body fatigue or dizziness	02/2013
l. ☐ Amnesia or confusion in evening hours	
m. ☑ Early awakenings or sleep disturbances	03/2013
n. ☐ Anxiety or apathy	
o. ☐ Hallucinations	
p. ☑ Delusions	04/2014

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

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

Date range treatment rendered (month/year): _____

Facility Name: _____

Specialty: _____ Phone #: _____ Fax #:_____

Address: _____

Other Physician Name: _____

Date range treatment rendered (month/year): _____

Facility Name: _____

Specialty: _____ Phone #: _____ Fax #:_____

Address: _____

Other Physician Name: _____

Date range treatment rendered (month/year): _____

Facility Name: _____

Specialty: _____ Phone #: _____ Fax #:_____

Address: _____

Other Physician Name: _____

Date range treatment rendered (month/year): _____

Facility Name: _____

Specialty: _____ Phone #: _____ Fax #:_____

Address: _____

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

Hospital Name: _____ Phone #: _____ Fax #:_____

Address: _____

Date range treatment rendered (month/year): _____

Hospital Name: _____ Phone #: _____ Fax #:_____

Address: _____

Date range treatment rendered (month/year): _____

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: _____ Phone #: _____ Fax #:_____

Address: _____

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

Address: _____