Hernia Mesh Class Action

Client Information Questionnaire

Client Identification

Name: _____
(First) (Middle) (Last)

Other Name/Aliases: _____

Current Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Date of Birth: _____

Health Care #: _____ Marital Status: _____

Spouse's Name: _____
(First) (Middle) (Last)

Emergency Contact

Name: _____
(First) (Middle) (Last)

Current Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Relationship: _____

Hernia Mesh Information

Approximate date original mesh was implanted: _____

City and hospital where original mesh was implanted: _____

Name and address of surgeon who implanted the original mesh:

Hernia Mesh Information (continued)

Brand name or type of mesh used, if known:_____

Have you received more than one hernia repair: ☐ Yes ☐ No

If yes, for each repair, please list:

a) The approximate dates of each repair:

b) The city/hospital where the repair occurred:

c) The name and address of the surgeon for each repair:

Has your mesh been removed: ☐ Yes ☐ No

If yes, please provide the name and address of the surgeon and the hospital/facility where the mesh was removed:

Has your mesh implant been replaced: ☐ Yes ☐ No

If yes, please provide the name and address of the surgeon and the hospital/facility where the mesh was replaced:

Hernia Mesh Information (continued)

What injuries or symptoms have you experienced or been diagnosed with AFTER the mesh was implanted?

Please check all selections that apply:

- ☐ Hernia recurrence
- ☐ Corrective Surgery
- ☐ Mesh removal
- ☐ Scarring
- ☐ Injury to surrounding organs
- ☐ Bowel/intestinal perforation
- ☐ Bowel/intestinal blockage
- ☐ Difficult bowel movements
- ☐ Blood in stool
- ☐ Mesh migration/movement
- ☐ Abscess or infection
- ☐ Mesh rip or tear
- ☐ Mesh adhesions
- ☐ Abdominal pain
- ☐ Bulging
- ☐ Emotional distress/anxiety/ depression

Other: _____

The approximate date when any of the above symptoms first arose AFTER the mesh was inserted:

_____

Name and address of the physician(s) who diagnosed you:

Name, address, and specialty of any other doctors involved in your mesh implantation or related problems:

Additional Questions

Future Treatment Plans: _____

Do you have your hospital/surgical records: ☐ Yes ☐ No

Name of current GP/family doctor: _____

Name of GP/family doctor at time of mesh insertion: _____

Name of GP/family doctor at time of mesh removal: _____

Employment Information

Status:

☐ Student ☐ Retired ☐ Other:

☐ Employed ☐ On Disability _____

☐ Unemployed ☐ Social Assistance

If employed:

Type of occupation:_____

Employer:_____

Date of hire:_____

Did you miss work due to an issue with your mesh? ☐ Yes ☐ No

If yes, approximately how much work have you missed?_____

If work missed, what is your income?_____
(Please provide hourly, monthly, or annually, whatever is most suitable to your circumstances)

Do you have extended medical coverage? ☐ Yes ☐ No

If yes, who is the provider:_____

What is the plan or certificate #:_____

Have you received disability benefits as a result of your mesh? ☐ Yes ☐ No

If yes, please provide details of amounts and time period:

_____

Additional Comments or Other Significant Health Problems or Illnesses Experienced Due to Hernia Mesh (include dates of onset)