
Were you hospitalized due to a heart attack, blood clots or a stroke as a result of Yaz®, Yasmin® or Ocella®? Yes No

If yes, please list name and address of hospital and dates of stay: _____

Please list the name, address and phone number of the doctor who prescribed Yaz®, Yasmin® or Ocella®:

Name: _____ *Phone:* _____

Address: _____

Do you have or can you get proof of the Yaz®, Yasmin® or Ocella® prescription? Yes No
 Unsure

Please list the name, address and phone number of the pharmacy where Yaz®, Yasmin® or Ocella® prescriptions were filled:

Name: _____ *Phone:* _____

Address: _____

Please list all other prescription and over-the-counter drugs you took while on Yaz®, Yasmin® or Ocella®:

Tests / Procedures at time of injury: *(Please check all that apply)*

<input type="checkbox"/> CT Scan	<input type="checkbox"/> EKG
<input type="checkbox"/> MRI	<input type="checkbox"/> Echocardiogram
<input type="checkbox"/> MRA	<input type="checkbox"/> Angioplasty
<input type="checkbox"/> Cardiac Catheterization	<input type="checkbox"/> Bypass Surgery

Other Test / Procedure _____

If yes, to any of the above procedures, when, where and do you know any results? _____

Have you ever been diagnosed with blood clots associated with a heart attack, stroke, pulmonary embolism or deep vein thrombosis while taking Yaz®, Yasmin® or Ocella®? Yes No Unsure

If yes, when, where and do you know any of the results? _____

Please check or list below any medical conditions you were diagnosed with prior to using and Yaz®, Yasmin® or Ocella®?

Heart attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other (<i>List Below</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Explain: _____

Spouse:	DOB:	SSN:
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Minor Children:	DOB:
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Decedent Information:

If you are filling this questionnaire due to the death of a loved one, please answer the questions below.

Your Name: _____
First Middle Last

Your Address: _____
Street City State Zip

Your Phone: () _____ **Phone 2:** () _____

Relationship to Decedent: _____ **Date of Death:** ____ / ____ / ____ **Age at Death:** _____

Was Yaz®, Yasmin®, Ocella®, heart attack, blood clots or stroke mentioned as a possible contributing cause of death? Yes No

If yes, please explain: _____

↪ (Please attach any additional comments or medical documents and return to us as soon as possible) ↪

Signature

Date
