



**MEDICAL HISTORY:**

Date started Raptiva:     \_\_\_/\_\_\_/\_\_\_

Date discontinued Raptiva:     \_\_\_/\_\_\_/\_\_\_

Physician Name/Address who prescribed Raptiva: \_\_\_\_\_

\_\_\_\_\_

Describe medical condition or reasons why you started Raptiva:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What did the Physician tell you, if anything, about the risks of **Raptiva**:

\_\_\_\_\_

\_\_\_\_\_

Name and address of all **pharmacies** where you had a prescription of Raptiva filled:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Were you ever given Raptiva directly from the Physicians office: \_\_\_ yes \_\_\_ no

If yes, **name/address** of Physicians office: \_\_\_\_\_

\_\_\_\_\_

List all **other medications** you were taking when you were taking Raptiva:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Physician(s)/facilities treating you for injuries from Raptiva: \_\_\_\_\_

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\_\_\_\_\_ (name) (address)

Have you been diagnosed or experienced any of the following conditions:

if yes, mark one (1) if diagnosed before taking Raptiva; and two (2) if diagnosed during or shortly after taking Raptiva

Bacterial Sepsis                      \_\_\_yes \_\_\_no                      date of diagnosis \_\_\_/\_\_\_/\_\_\_

Viral Meningitis                      \_\_\_ yes \_\_\_ no                      date of diagnosis \_\_\_/\_\_\_/\_\_\_

Invasive Fungal Disease                      \_\_\_ yes \_\_\_ no                      date of diagnosis \_\_\_/\_\_\_/\_\_\_

PML                      \_\_\_ yes \_\_\_ no                      date of diagnosis \_\_\_/\_\_\_/\_\_\_

Other Infections                      \_\_\_ yes \_\_\_ no                      date of diagnosis \_\_\_/\_\_\_/\_\_\_

If so, what type of infection(s) \_\_\_\_\_

Any Immune Deficiency Disease                      \_\_\_yes \_\_\_no                      date of diagnosis \_\_\_/\_\_\_/\_\_\_

If so, what type of disease(s) \_\_\_\_\_

While taking Raptiva, did you ever experience the following conditions?

Weakness in one side of body                      \_\_\_yes \_\_\_no

Loss or Blurred Vision                      \_\_\_yes \_\_\_no

Fatigue                      \_\_\_yes \_\_\_no

Memory Loss                      \_\_\_yes \_\_\_no

Disorientation                      \_\_\_yes \_\_\_no

Loss of Balance                      \_\_\_yes \_\_\_no

Do you have any other health condition which you believe was caused by the medication Raptiva? If so, state **condition, symptoms and the date this occurred:** \_\_\_\_\_

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Did a Physician ever tell you that you were injured as a result of taking Raptiva: \_\_\_\_ yes \_\_\_\_ no

If so, when: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Family History:** Mother, Father, Sisters, Brothers; Alive & Well? \_\_\_\_\_

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**Major Illnesses** among family members: \_\_\_\_\_

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Previous Illnesses/prior Hospitalizations: \_\_\_\_\_

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Present Family Physician: (address & phone #): \_\_\_\_\_

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