

POTENTIAL CLASS MEMBER QUESTIONNAIRE -  
PERMAX®

**PLEASE NOTE THAT THE INFORMATION YOU ARE PROVIDING IN THIS QUESTIONNAIRE WILL BE PROVIDED TO THE DEFENDANTS IN THIS CLASS ACTION FOR THE PURPOSE OF EVALUATING YOUR CLAIM. HOWEVER, THE INFORMATION PROVIDED WILL OTHERWISE REMAIN CONFIDENTIAL AND YOUR PRIVACY & SECURITY WILL BE MAINTAINED.**

**1. PERSONAL INFORMATION**

a) Full Name \_\_\_\_\_

b) Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

c) Current Mailing Address

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

d) Primary Telephone Number \_\_\_\_\_

Other Telephone Number(s) \_\_\_\_\_

e) Provincial Health Insurance Plan Number \_\_\_\_\_

f) Social Insurance Number \_\_\_\_\_

g) Family Information: If you believe that Permax has had an impact on your family relationships, please provide family member(s) name(s) (and identify their relationship to you)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

h) Bankruptcy: Have you ever filed for bankruptcy? Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered "Yes", please advise when you filed for bankruptcy and whether and when you were discharged:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. PERMAX AND MEDICATION HISTORY**

- a) Have you ever taken the drug Permax® (generic name: pergolide mesylate)?  
 Yes \_\_\_\_\_ No \_\_\_\_\_
- b) For what condition were you taking Permax?  
 Parkinson’s Disease \_\_\_\_\_ Restless Leg Syndrome \_\_\_\_\_ Other (specify) \_\_\_\_\_

If you answered “Yes” to (a), complete the following:

Start Date (list all start and stop dates if there was a period of non-consumption)	Stop Date (insert the dates(s) and reason(s) why you stopped taking Permax)	Dosage (make sure to list all dosage changes along with dates)

- c) Please provide the names and locations of the pharmacies (or other sources) where you usually obtained Permax and any other medications:

Pharmacy Name and Address \_\_\_\_\_  
 Pharmacy Name and Address \_\_\_\_\_  
 Pharmacy Name and Address \_\_\_\_\_  
 Identify any other sources: \_\_\_\_\_

- d) Have you ever taken any of the following medications?

Medication	Yes	No	If ‘Yes’ please provide your start and stop dates and dosage information
Parlodel (generic name: Bromocriptine)			
Mirapex (generic name: Pramipexole)			
Requip (generic name: Ropinirole)			
Dostinex (generic name: Selegiline)			

**YOU MUST CONTACT THE PHARMACIES INVOLVED AND OBTAIN AND PROVIDE ALL AVAILABLE PHARMACEUTICAL RECORDS LISTING ALL OF THE MEDICATIONS, INCLUDING PERMAX, THAT YOU HAVE TAKEN (THE RECORDS SHOULD GO BACK AS FAR AS POSSIBLE)**

(If this information is not available from the pharmacies, please obtain and provide any other information to confirm your use of Permax during these time periods)

### 3. MEDICAL HISTORY

a) **Before taking Permax**, were you ever diagnosed with or treated for any of the following addictions, behaviours, disorders, or conditions:

- Eating disorders such as anorexia, bulimia, food addictions, or obesity
- Psychological, mental, or emotional issues such as anxiety, depression, hysteria, obsessions, compulsions, mania, neurosis, or other mental health issues
- Excessive use of food, drugs, alcohol, smoking, sex, shopping, gambling, or any kind of addiction

Yes \_\_\_\_\_ No \_\_\_\_\_

b) If the answer to (a) is “Yes”, please identify and provide detailed information about the nature of the condition, the time period over which you experienced the condition, and any treatment you received (attach additional pages if necessary):

---

---

---

---

---

---

---

---

c) **Since you stopped taking Permax** have you been diagnosed with or treated for any of the addictions, behaviours, disorders, or conditions mentioned in (a)?

Yes \_\_\_\_\_ No \_\_\_\_\_

d) If the answer to (c) is “Yes”, please identify and provide detailed information about the nature of the condition, the time period over which you experienced the condition, and any treatment you received (attach additional pages if necessary):

---

---

---

---

---

---

---

---

e) To your knowledge, has a parent, sibling, or child of yours been diagnosed with, or treated for any of the addictions, behaviours, disorders, or conditions mentioned in (a)?

Yes \_\_\_\_\_ No \_\_\_\_\_ Do not know \_\_\_\_\_

**4. GAMBLING HISTORY**

**COMPLETE THIS PAGE ONLY IF YOU ARE CLAIMING THAT PERMAX CAUSED YOU TO GAMBLE**

- a) **Before taking Permax**, how would you describe your gambling behaviour (please circle the most accurate response):

**Frequency**

Daily      Weekly      Monthly      Occasionally      Never

**Locations**

Casino      Bar (VLTs)      Lottery      Horse Track      Other (specify): \_\_\_\_\_

**Type of gambling**

Lottery      Video-poker      Casino      Racing      Other (specify): \_\_\_\_\_

- b) **Before taking Permax**, how much money did you lose gambling on average per year: Estimated amount lost per year \$ \_\_\_\_\_

- c) **Before taking Permax**, were you taking Mirapex, Requip, Parlodel, or Dostinex:  
Yes \_\_\_\_\_ No \_\_\_\_\_

- d) Have you ever won money while gambling?  
Yes \_\_\_\_\_ No \_\_\_\_\_

If the answer to (d) is "Yes", please fill in the following:

- (approximate) date of your first win: \_\_\_\_\_
- amount of money won on that occasion: \_\_\_\_\_
- location: \_\_\_\_\_
- type of game: \_\_\_\_\_

- e) Did you gamble after you stopped taking Permax? Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered "Yes" to (e), please estimate your approximate gambling losses per year **since you stopped taking Permax**:

Estimated amount lost per year \$ \_\_\_\_\_

If you answered "No" to (e), when did you stop gambling?  
\_\_\_\_\_

- f) Have you ever received therapy for gambling problems? Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered "Yes" to (f), please provide details of treating therapist, type of programme, and dates of treatment (attach additional sheets if necessary):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**5. GAMBLING WHILE TAKING PERMAX**

**COMPLETE THIS PAGE ONLY IF YOU ARE CLAIMING THAT PERMAX CAUSED YOU TO GAMBLE**

- a) **While taking Permax**, what kinds of gambling did you engage in (identify all types of gambling you engaged in):

---

---

---

- b) **Over the period in which you were taking Permax**, did you withdraw any money from ATM specifically for gambling? Yes \_\_\_ No \_\_\_

If "Yes" what was the total sum withdrawn from ATMs for gambling over the period in which you were taking Permax: \$ \_\_\_\_\_

- c) **Over the period in which you were taking Permax**, did you make credit card transactions for gambling? Yes \_\_\_ No \_\_\_

If "Yes", what was the total sum withdrawn from, or charged to, credit cards for gambling over the period in which you were taking Permax: \$ \_\_\_\_\_

- d) Describe in detail any other financial transactions you participated in to access money for gambling over the period in which you were taking Permax:

---

---

---

- e) What was the total sum withdrawn by means of these other financial transactions that you used for gambling over the period in which you were taking Permax? \$ \_\_\_\_\_

- f) What are the total estimated net gambling losses (total losses minus total winnings) during the time you were taking Permax?

\$ \_\_\_\_\_

**YOU MUST OBTAIN AND PROVIDE ALL DOCUMENTS CONFIRMING THESE WITHDRAWALS OR TRANSACTIONS**

(If this information is not available, please obtain and provide any other information to confirm the withdrawals and/or other transactions set out above)

**6. OTHER IMPACTS AND LOSSES/EXPENSES FROM PERMAX**

a) Did you, at any time **while taking Permax**, acquire any non-gambling impulse control disorders (e.g.: uncontrollable eating, shopping, sexual habits, compulsive body picking, etc.): Yes \_\_\_\_\_ No \_\_\_\_\_

b) If you answered “Yes” to (a), please describe the nature of this behaviour in detail (attach additional pages if necessary):

---

---

---

---

c) Do you believe that Permax impacted your ability to earn an income in any way?  
Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered “Yes”, please describe how Permax impacted your ability to earn an income and estimate the amount of income you believe you have lost as a result (attach additional pages if necessary):

---

---

---

d) Did you suffer any other expenses (e.g.: medical, legal, etc.) as a result of any impact that you believe Permax has had on you?

Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered “Yes”, please describe these expenses and provide the total amount of these expenses (attach additional pages if necessary):

---

---

---

---

**YOU MUST OBTAIN AND PROVIDE ALL DOCUMENTS CONFIRMING THESE LOSSES AND/OR EXPENSES**

(If this information is not available, please obtain and provide any other information to confirm these losses and/or expenses)

**7. PHYSICIAN AND OTHER MEDICAL INFORMATION**

a. Who is your family doctor?

Name \_\_\_\_\_  
Mailing Address of Physician \_\_\_\_\_  
Phone Number of Physician \_\_\_\_\_

b. Who is the doctor that prescribed Permax to you?

Name \_\_\_\_\_  
Type of Physician \_\_\_\_\_  
Mailing Address of Physician \_\_\_\_\_  
Phone Number of Physician \_\_\_\_\_

c. What other doctor(s) and/or health professional(s) prescribed Permax to you, or has awareness of its impacts on you?

Name \_\_\_\_\_  
Type of Physician or health professional \_\_\_\_\_  
\_\_\_\_\_  
Mailing Address of Physician \_\_\_\_\_  
Phone Number of Physician \_\_\_\_\_

Name \_\_\_\_\_  
Type of Physician or health professional \_\_\_\_\_  
\_\_\_\_\_  
Mailing Address of Physician \_\_\_\_\_  
Phone Number of Physician \_\_\_\_\_

**THOMSON, ROGERS WILL BE WRITING TO THESE DOCTORS  
USING THE AUTHORIZATIONS ATTACHED THAT YOU MUST  
SIGN AND RETURN TO US**

**WE WILL BE ASKING FOR THESE DOCTORS' RECORDS TO  
HELP ESTABLISH YOUR CLAIM**

