Please do your best to answer the following questions as completely as possible. **The questionnaire is broken into sections and some questions *may not* be applicable to you specifically. If not, please bypass that section/question(s). This questionnaire is to simply help us determine how you may have been impacted by Stericycle in N. Salt Lake City, UT.** If answering this questionnaire on your own behalf, please answer the each question with **your** information. However, if you are answering this document on behalf of someone else (i.e.: a minor, deceased or an incapacitated person), please answer questions 1 through 8 with *your* information and questions 9 through 23 on behalf of the injured person.

◯ **I am responding on my own behalf** ◯ **I am responding on behalf of another person**

I. RESPONDENT'S BACKGROUND

1. **YOUR FULL NAME**: _____

2. **DATE OF BIRTH:** _____

3. **GENDER:** ◯ **Male** ◯ **Female**

4. **SOCIAL SECURITY NUMBER**: _____

5. **CURRENT MAILING ADDRESS**:

Address: _____

City: _____ State: _____ Zip: _____

PHONE/E-MAIL:

Home: _____ Mobile: _____

Work: _____ Other: _____

Email: _____ Email 2: _____

6. **EMPLOYER INFORMATION**: *Please provide the following:*

Employer's Name: _____ Years Employed: _____

Address: _____ Telephone: _____

7. **EMERGENCY CONTACT:** *Please provide the following for an Emergency Contact Person for you and* ***who does not live in your home****:*

Contact's Name: _____ Relationship: _____

Address: _____ Telephone: _____

8. **WHAT IS YOUR CURRENT MARITAL STATUS?**

a. ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

b. Spouse: _____ Date of Birth: _____

Wedding Date: _____ Place of Marriage: _____

c. If you have ever been known by another name, please list the other names and dates of use.

_____ _____ to _____

_____ _____ to _____

_____ _____ to _____

9. IF YOU ARE <u>RESPONDING FOR ANOTHER PERSON</u>, ANSWER THE REMAINDER OF THE QUESTIONS ON *<u>BEHALF OF THIS INJURED INDIVIDUAL</u>*.

a. Injured's Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

b. Please indicate all of the following that apply to the person on whose behalf you are responding:

◯ Minor ◯ Deceased ◯ Incapacitated ◯ Other (specify: _____)

c. Please state the person's relationship to you. _____

d. Injured Person's Social Security Number: _____

e. ◯ Male ◯ Female

f. Date of Birth: _____

g. If the person on whose behalf you are responding is deceased, please state the following:

Date of Death: _____ Age at Death: _____

Cause of Death: _____

Please attach a copy of the decedent's death certificate if you have it in your possession.

Place of Death: _____

h. If an autopsy was performed, please attach a copy of the autopsy report, or provide the name and address of the doctor, clinic, or hospital conducting the autopsy.

Doctor's/Hospital's Name _____

Address: _____ Telephone: _____

10. CHILDREN: Please provide the name and date of birth of each child, living or deceased.

1. _____
2. _____
3. _____
4. _____
5. _____

II. RESIDENTIAL, PROPERTY & EXPOSURE HISTORY

11. ARE YOU NOW, OR HAVE YOU EVER BEEN AN EMPLOYEE STERICYCLE?

No: ◯ Please skip to question #12

Yes: ◯ Please answer the following questions:

Years: _____to_____ Job Title: _____

Site worked at: _____

If you are a memeber of a Union, please identify the Union:_____

Duties performed:

Did you change out of your work clothes immediately when you got home? Please explain.

12. IF YOU WORKED FOR A SUB-CONTRACTOR AT STERICYCLE, PLEASE LIST THE FOLLOWING:

Sub-Contractor: Years Employed:

Address: Job Title:

Duties:

13. **PLEASE PROVIDE THE FOLLOWING OWNERSHIP/RENTAL INFORMATION ON YOUR *CURRENT* RESIDENCE AND OR BUSINESS NEAR STERICYCLE. Please use additional pages if necessary.**

Address: _____

City: _____ State: _____ Zip: _____

Years at this address: _____ to _____

- Do you ☐ Own ☐ Rent/Lease ☐ Other ☐ More than 1 property or business
- Who is listed on the ownership title? _____
- What documents, if any, do you have to show ownership or rental interest? _____
- When did you purchase this property? _____ Purchase Price: $_____
- Balance owed on property? $_____ Monthly Mortgage Payment: $_____
- Mortgage Bank's Name: _____
- Bank's Address: _____
- Bank's Telephone No: _____ Loan No.: _____
- If you rent or lease, who is the property owner/manager? _____
- What are the years of residency at this property? _____
- What kind of property is this? ☐ Single Family Home ☐ Mobile/Manufactured ☐ Farm/ranch ☐ Commercial ☐ Vacant Land ☐ Other
- Do you have insurance on this property? ☐ No ☐ Yes
- If yes, please provide insurance information: _____
- Have you made an insurance claim related to this issue? ☐ No ☐ Yes
- If yes, type & status: _____
- What is the fair market value of your property? _____
- In your opinion, have you suffered a loss in property value? ☐ No ☐ Yes
- If yes, please explain:

- Where did/does your *household* water come from?
  ☐ Municipality ☐ Private well ☐ Other ☐ Don't know
- Where did/does your ***drinking*** water come from?
  ☐ Municipality ☐ Private well ☐ Bottled water ☐ Other ☐ Don't know

- If you have a private well on your property, please identify for what purpose you use your well: (i.e. irrigation, livestock, household water, drinking water, etc.)

- Do you have an attic or basement in your home? ☐ No ☐ Yes
- If yes, describe):

14. PLEASE LIST ANY AND ALL ADDRESSES YOU HAVE OCCUPIED OR OWNED WHILE LIVING NEAR STERICYCLE *Please use additional pages if necessary.*

a.

Address: _____

City: _____ State: _____ Zip: _____

What years did you live at this address: _____ to _____

- Did/do you ☐ Own ☐ Rent/Lease ☐ Other
- Where did/does your household water come from?
  ☐ Municipality ☐ Private well ☐ Other ☐ Don't know
- Where did/does your ***drinking*** water come from?
  ☐ Municipality ☐ Private well ☐ Bottled water ☐ Other ☐ Don't know
- What documents, if any, do you have to show ownership or rental interest?
- Is there an attic or basement in this home? ☐ No ☐ Yes
- If yes, describe: _____
- Do you have abnormal/excessive dust in your home living near STERICYCLE? ☐ No ☐ Yes
  If yes, please explain:

b.

Address: _____

City: _____ State: _____ Zip: _____

What years did you live at this address: _____ to _____

- Did/do you ☐ Own ☐ Rent/Lease ☐ Other

- Where did/does your household water come from?
  ☐ Municipality ☐ Private well ☐ Other ☐ Don't know
- Where did/does your ***drinking*** water come from?
  ☐ Municipality ☐ Private well ☐ Bottled water ☐ Other ☐ Don't know
- What documents, if any, do you have to show ownership or rental interest?
- Is there an attic or basement in this home? ☐ No ☐ Yes
- If yes, describe:_____
- Do you have abnormal/excessive dust in your home living near STERICYCLE? ☐ No ☐ Yes
  If yes, please explain:

c.

Address: _____

City: _____ State: Zip: _____

What years did you live at this address: _____ to _____

- Did/do you ☐ Own ☐ Rent/Lease ☐ Other
- Where did/does your household water come from?
  ☐ Municipality ☐ Private well ☐ Other ☐ Don't know
- Where did/does your ***drinking*** water come from?
  ☐ Municipality ☐ Private well ☐ Bottled water ☐ Other ☐ Don't know
- What documents, if any, do you have to show ownership or rental interest?
- Is there an attic or basement in this home? ☐ No ☐ Yes
- If yes, describe:_____
- Do you have abnormal/excessive dust in your home living near STERICYCLE? ☐ No ☐ Yes
  If yes, please explain:

d.

Address: _____

City: _____ State: _____ Zip: _____

What years did you live at this address: _____ to _____

- Did/do you ☐ Own ☐ Rent/Lease ☐ Other
- Where did/does your household water come from?
  ☐ Municipality ☐ Private well ☐ Other ☐ Don't know
- Where did/does your ***drinking*** water come from?
  ☐ Municipality ☐ Private well ☐ Bottled water ☐ Other ☐ Don't know
- What documents, if any, do you have to show ownership or rental interest?
- Is there an attic or basement in this home? ☐ No ☐ Yes
- If yes, describe_____:_____
- Do you have abnormal/excessive dust in your home living near STERICYCLE? ☐ No ☐ Yes
  If yes, please explain:

e.

Address: _____

City: _____ State: _____ Zip: _____

What years did you live at this address: _____ to _____

- Did/do you ☐ Own ☐ Rent/Lease ☐ Other
- Where did/does your household water come from?
  ☐ Municipality ☐ Private well ☐ Other ☐ Don't know
- Where did/does your ***drinking*** water come from?
  ☐ Municipality ☐ Private well ☐ Bottled water ☐ Other ☐ Don't know
- What documents, if any, do you have to show ownership or rental interest?

- Is there an attic or basement in this home? ☐ No ☐ Yes
- If yes, describe:_____
- Do you have abnormal/excessive dust in your home living near STERICYCLE? ☐ No ☐ Yes
  If yes, please explain:

15. PLEASE LIST ANY OTHER AREA WHERE YOU BELIEVE YOU MAY HAVE BEEN EXPOSED TO TOXIC CHEMICALS EMANATING FROM STERICYCLE (i.e. outdoor activities i.e. gardening, swimming pools, schools, church, sports, dust in home, etc.)

III. HEALTH

16. In the following section, please check any illness or symptoms you presently have or have had in the past *if you believe your health could have been harmed by living near the Site.* If possible, please indicate when the symptoms and if/when they stopped. If symptoms persist, please indicate by writing "still present." You may leave any space blank if the condition does not apply. Please use additional pages if necessary. PLEASE NOTE THAT THE CONTAMINANT(S) ASSOCIATED WITH STERICYCLE *MAY OR MAY NOT* BE THE CAUSE OF ANY SYMPTOMS YOU CHECK.

CANCER or BENIGN TUMORS (check all that apply)

Type	Cancer	Benign	Diagnosis Date	Treated by Doctor	
				Yes	No
Anorectal					
Bladder					
Bone					
Brain					
Breast					
Cervical					
Colon					
Esophageal					
Hodgkin's Lymphoma					
Kidney					
Leukemia (ALL or AML)					
Leukemia (Schillings)					
Liver					
Lung					
Multiple Myeloma					
Mesothelioma					
Mouth/Lip					
Nasopharynx					
Non-Hodgkin's Lymphoma					
Ovarian					
Pancreatic					
Pituitary					
Prostate					
Skin Melanoma					
Skin Carcinoma					
Soft-Tissue sarcoma					
Stomach					
Testicular					
Thyroid					
Tongue					
Uterine					
Other:					

Is there a family history of cancer? ☐ No ☐ Yes

Is there a family history of benign tumors? ☐ No ☐ Yes

(If yes, please list name, relationship to you, whether or not that person is living or deceased, and finally, if that person lived near STERICYCLE.)

NERVOUS SYSTEM

Symptom or Problem	Onset	Still Present or Stopped	Treated by Doctor	
			Yes	No
Anxiety				
Attention problems				
Balance problems				
Concentration problems				
Depression				
Difficulty expressing thoughts verbally				
Difficulty following directions				
Difficulty following through with responsibilities at home/work				
Dizziness				
Episodes of shock in body				
Fainting/Blacking out				
Fatigue				
Handwriting changes				
Headaches				
Hyperactivity				
Increased frustration				
Insomnia				
Irritable / easily angered				
Learning disabilities				
Memory loss – long term				
Memory loss – short term				
Muscular jerking/twitching				
Numbness in Extremities				
Pins/needles feeling				
Problems doing math				
Reduced reasoning				
Seizures				
Slowed responses				
Stumbling				
Uncontrollable sleepiness				
Word finding difficulty				

EYES, EAR, NOSE, MOUTH, THROAT & HEAD

Symptom or Problem	Onset	Still Present or Stopped	Treated by Doctor Yes	Treated by Doctor No
Bad or metallic taste in mouth				
Bleeding gums				
Blurred vision				
Decreased hearing				
Difficulty swallowing				
Double vision				
Dry eyes				
Dry mouth				
Earaches				
Excessive tearing				
Eyes burning or irritated				
Loose or brittle teeth				
Nosebleeds				
Other				
Print moving or vibrating on page				
Problems focusing				
Reduced taste and/or smell				
Ringing in ears				
Sinus infections or tenderness				
Other:				

RESPIRATORY SYSTEM

Symptom or Problem	Onset	Still Present or Stopped	Treated by Doctor Yes	Treated by Doctor No
Asbestosis				
Asthma / wheezing				
Berylliosis				
Bronchitis				
Chronic cough				
Chronic hoarseness				
COPD				
Coughing up blood				
Emphysema				
Lung calcifications / scarring				
Lung sarcoidosis				
Pneumonia				
Shortness of breath				
Silicosis				
Sinusitis				
Sore throat				
Other				

HEART/CIRCULATORY SYSTEM:

Symptom or Problem	Onset	Still Present or Stopped	Treated by Doctor	
			Yes	No
Anemia				
Aneurysm				
Angina				
Blood clotting				
Chest pain or discomfort				
Cold hands / feet				
Congestive heart failure				
Heart attack				
Heart surgery				
High blood pressure				
Irregular heart beats				
Low blood pressure				
Rapid heart rate				
Stroke				
Other				

GASTROINTESTINAL TRACT

Symptom or Problem	Onset	Still Present or Stopped	Treated by Doctor	
			Yes	No
Abdominal pain				
Abnormal liver tests				
Chronic nausea or vomiting				
Colitis				
Crohn's Disease				
Diverticulitis				
Gall stones				
Gallbladder inflamed				
Gallbladder removed				
Heartburn / Acid reflux				
Hepatitis				
Irritable Bowel Syndrome				
Jaundice				
Liver failure				
Liver transplant				
Pancreatitis				
Ulcerative Colitis				
Other				

GENITOURINARY TRACT

Symptom or Problem	Onset	Still Present or Stopped	Treated by Doctor	
			Yes	No
Blood in urine				
Dialysis				
Incontinence				
Kidney disease				
Kidney failure				
Kidney failure				
Kidney infections				
Kidney stones				
Pelvic pain				
Prostate issues				
Unusual bed wetting				
Urinary tract infections				
Urination – frequent or urgent				
Urination – painful or burning				
Other				

SKIN & MUSCULOSKELETAL SYSTEM

Symptom or Problem	Onset	Still Present or Stopped	Treated by Doctor	
			Yes	No
Acne-like rash				
Arthritis				
Blister-like rash				
Bone degeneration				
Bone, joint or other deformity				
Brittle bones				
Bruise easily				
Eczema				
General stiffness				
General weakness				
Joint pain				
Leg cramps				
Muscle aches				
Osteoporosis				
Psoriasis				
Slow recovery from injury				
Sores or ulcerations on body				
Sunburn-like rash				
Other				

AUTOIMMUNE AND OTHER DISORDERS

Symptom or Problem	Onset	Still Present or Stopped	Treated by Doctor	
			Yes	No
Addison's Disease			☐	☐
Alzheimer's or dementia			☐	☐
Autism			☐	☐
Chronic Fatigue Syndrome			☐	☐
Dermatomyositis			☐	☐
Diabetes Mellitus Type 1			☐	☐
Diabetes Mellitus Type 2			☐	☐
Epilepsy			☐	☐
Epstein Barr Syndrome			☐	☐
Fibromyalgia			☐	☐
Grave's Disease			☐	☐
Hashimoto's Thyroiditis			☐	☐
Hyper or hypo pituitary			☐	☐
Hyper or hypo thyroid			☐	☐
Lupus, Discoid			☐	☐
Lupus, Systemic			☐	☐
Multiple Chemical Sensitivity			☐	☐
Multiple Sclerosis			☐	☐
Myasthenia Gravis			☐	☐
Parkinson's Disease			☐	☐
Pernicious Anemia			☐	☐
Raynaud's Syndrome			☐	☐
Rheumatoid Arthritis			☐	☐
Scleroderma			☐	☐
Sjogren's Syndrome			☐	☐
Surgery(s)				
Other			☐	☐

17. HEALTH CARE PROVIDERS

Please do your best to list your doctors from the last 10 years & provide a copy of all medical records ***in your possession*** *or records readily available to you regarding your medical history. If you do not have any records in your possession at this time, it is okay to submit this questionnaire without them.*

a.

Name of Medical Provider: _____

Address: _____

Telephone: _____

Website (if known) _____

Specialty: _____

Condition(s) treated _____

Date(s) of Treatment _____

Has this medical provider ever told you that exposure to STERICYCLE or toxic chemicals caused your health problems? ___Yes ___No ○ ○

b.

Name of Medical Provider: _____

Address: _____

Telephone: _____

Website (if known) _____

Specialty: _____

Condition(s) treated _____

Date(s) of Treatment _____

Has this medical provider ever told you that exposure to STERICYCLE or toxic chemicals caused your health problems? ___Yes ___No ○ ○

c.

Name of Medical Provider: _____

Address: _____

Telephone: _____

Website (if known) _____

Specialty: _____

Condition(s) treated _____

Date(s) of Treatment _____

Has this medical provider ever told you that exposure to STERICYCLE or toxic chemicals caused your health problems? ___Yes ___No ○ ○

d.

Name of Medical Provider: _____

Address: _____

Telephone: _____

Website (if known) _____

Specialty: _____

Condition(s) treated _____

Date(s) of Treatment _____

Has this medical provider ever told you that exposure to STERICYCLEor toxic chemicals caused your health problems? ___Yes ___No

e.

Name of Medical Provider: _____

Address: _____

Telephone: _____

Website (if known) _____

Specialty: _____

Condition(s) treated _____

Date(s) of Treatment _____

Has this medical provider ever told you that exposure to STERICYCLE or toxic chemicals caused your health problems? ___Yes ___No

18. HAVE YOU EVER USED TOBACCO PRODUCTS? (Please specify if product(s) is cigarettes, cigars, pipe, snuff, and/or chewing tobacco).

a. ☐ No

b. ☐ Yes: *Please answer the following questions*:

c. What year did you start using tobacco products? _____

d. What types of tobacco products have you used? _____

e. How much do/did you use tobacco products on an average day? _____

f. Are you currently using tobacco products? ☐Yes ☐ No When did you quit? _____

19. DO YOU NOW, OR DID YOU EVER DRINK ALCOHOLIC BEVERAGES?

a. ☐ No

b. ☐ Yes: *Please answer the following questions*:

c. What year did you start drinking? _____

d. How much do/did you drink on an average day? _____

e. Are you currently drinking? ☐ Yes ☐ No When did you quit? _____

20. HAVE YOU READ ANY INFORMATION, SUCH AS FLYERS, ATTENDED COMMUNITY MEETINGS, COMMUNITY NEWSLETTERS, NEWSPAPER ARTICLES THAT DISCUSSED STERICYCLE CAUSING CONTAMINATION?

☐ No ☐ Yes (If yes, please explain)

a. Where did you see/hear the information:_____

b. What dates: _____

c. What specifically did you hear or read? _____

21. DID YOU EVER READ OR HEAR THAT STERICYCLE HAS *NOT* POSED A HEALTH RISK TO THE COMMUNITY SURROUNDING IT?

☐ No ☐ Yes (If yes, please explain)

a. Where did you hear/read about this? _____

b. Where did you get this information? _____

22. HAVE YOU EVER RECEIVED ANY DIRECT INFORMATION FROM STERICYCLE REGARDING POTENTIAL CONTAMINATION?

☐ No ☐ Yes (If yes, please explain)

Date received _____

23. HAVE YOU BEEN IN CONTACT WITH ANY OTHER LAW FIRM BESIDES VITITOE LAW GROUP AND/OR GIRARDI | KEESE REGARDING STERICYCLE?

☐ NO ☐ YES (If yes, please list the name of the law firm, any contact information, an approximate date you were contacted, and the reason why you were contacted).

****

Thank you for completing this questionnaire as to how you may have been impacted by the STERICYCLE contamination. Completing this form helps us determine what your damages may be and how we best could help you. This is NOT a legal agreement hiring either Girardi | Keese or Vititoe Law Group to represent you. The Legal Services Agreement is a different document.

We realize it may not have been easy to complete and we appreciate your cooperation.

Please return this questionnaire to:**Vititoe Law Group at 5707 Corsa Avenue, 2nd Floor, Westlake Village, CA 91362 or email to melissa@vititoelawgroup within two weeks of receipt of this questionnaire.**

Signed: _____ Dated: _____

Printed: _____