

Medical History and Records.

1. Were you afflicted with or suffering from any medical condition, including illness, injury, ailment, infirmity, impairment or disability, before this cause of action arose?
2. If the answer to the preceding interrogatory is in the affirmative, please state as to each such condition:
 - a. A full and complete description of any such condition, including its nature, extent and severity,
 - b. The duration in time, in months and days, that you had any such condition,
 - c. Any medical or hospital examination, treatment, or care you had received for any such condition,
 - d. The names and addresses of any doctor or hospital involved with any examination, treatment or care of any such condition,
 - e. The dates of each and every such examination, treatment or care for any such condition,
 - f. Your entire medical history as it relates in any way to any such condition.
3. Please set forth fully and completely your entire medical history as it may refer to any injury, disability, condition, or illness, stating in your answer the nature and extent of all treatments given therefor, the dates thereof, and the names and addresses of all doctors or hospitals involved.
4. If the general physical or mental condition of your health during each of the five years preceding this claim has been other than normal in any particular, describe the details thereof.
5. Please list all medications, prescription and nonprescription, that you take on a regular or irregular basis and the reason for each.
6. Please identify the date of your last physical and the name and address of the physician who performed it.
7. Please identify all health care providers by name and address who have provided you with medical services during the last five years.
8. If at any time during the last five years you have received, been the subject of, or were tested by the use of, any diagnostic aid or procedure, including x-ray, electroencephalogram, electrocardiogram, or other such aid or procedure, please state:
 - a. The date of each such diagnostic aid or procedure,
 - b. The name and address of each such doctor, hospital, or laboratory in charge of each such diagnostic aid or procedure,
 - c. In detail, the results and findings of each such diagnostic aid or procedure as determined by each such doctor, hospital, or laboratory responsible therefor,
 - d. In detail, any and all diagnoses of your medical condition made by any such doctor, hospital, or laboratory based in whole or in part, specifying which, on any such diagnostic aid or procedure,
 - e. In detail, any and all prognoses of your medical condition made by any such doctor, hospital, or laboratory based in whole or in part, specifying which, on any such diagnostic aid or procedure.

Mental Health History and Records.

1. Please state whether you have received or undergone any psychiatric treatment?
2. If the answer to the preceding interrogatory is in the affirmative, please state:
 - a. The nature and extent of any such treatment,
 - b. The dates of any such treatment,
 - c. The name and address of any doctor or practitioner treating you.
3. Please state whether you have ever received a diagnosis indicating any mental or emotional disturbance?
4. If the answer to the preceding interrogatory is in the affirmative, please state:
 - a. The nature and extent of any such mental or emotional disturbance,
 - b. The date or dates of any such mental or emotional disturbance,
 - c. The name and address of any doctor or practitioner, or hospital or other institution, involved in any way in any examination, treatment or care for any such mental or emotional disturbance.
5. Please state whether you have ever had any form of mental illness, nervous breakdown, fits, convulsion, fainting spells, epilepsy, venereal disease, or tuberculosis?
6. If the answer to the preceding interrogatory is in the affirmative, please state as to each condition:
 - a. The date of any occurrence,
 - b. The name and address of any doctor, practitioner, hospital, or other institution treating you for any such condition.
7. Please state whether you have ever been treated for alcoholism by any doctor, practitioner, hospital, or other institution?
8. If the answer to the preceding interrogatory is in the affirmative, please state:
 - a. The date or dates of any such treatment,
 - b. The name and address of any person or institution treating you,
 - c. The nature and extent of any such treatment.
9. Please describe as fully as possible the amount and regularity of the consumption of any alcoholic beverages by you during the past five years, indicating in your answer the nature of any such beverages and the apparent physical effects any such consumption had on you.
10. Please state whether or not you have ever taken or ingested any drug, narcotic, sedative, tranquilizer, or any other form of medication or medical preparation.
11. If the answer to the preceding interrogatory is in the affirmative, please state:
 - a. The date and time of the use of any such medication,
 - b. The place or location, identifying hospital, doctor's office, laboratory, or otherwise, where used,
 - c. The name and address of the person, doctor, practitioner, hospital, or laboratory who prescribed or administered such medication,

d. The date of treatment for overdose or excess ingestion.

Treatments and Medications.

1. Please identify all medications and treatments that you have taken in the past five years.
2. For each treatment or medication identified in the preceding interrogatory, please state as to each such condition for which each treatment or medication was prescribed:
 - a. The nature, extent, and severity of any such condition,
 - b. Any medical or hospital examination, treatment or care you had received for any such condition,
 - c. The names and addresses of any doctor or hospital involved with any examination, treatment or care of any such condition,
 - d. The dates of any such examination, treatment or care of any such condition,
 - e. The date when any such condition first began,
 - f. The date when any such condition ceased or diminished, even temporarily,
 - g. The outward manifestations or appearances of any such condition.
3. Please give the names and addresses of all doctors, medical practitioners, hospitals, or other institutions providing examination, treatment or prescriptions for any condition you may have had in the last five years.
4. Please provide the monthly costs of all medications and treatments received in the last five years.

Disabilities.

1. Please state the date when you claim you were:
 - a. Totally disabled from your normal activities,
 - b. Partially disabled from your normal activities.
2. Please itemize each and every activity as to which you are totally disabled.
3. Please itemize each and every activity as to which you were partially disabled.
4. Please describe the full extent of the effect of your disabilities on any of the following activities:
 - a. Get out of your bed to use the toilet,
 - b. Sit up in a chair for more than one hour,
 - c. Get out of bed so you were no longer wholly confined to bed,
 - d. Remain out of bed all day,
 - e. Join your family regularly at meals,
 - f. Use your washing machine or dryer,
 - g. Do any cleaning, dusting, or washing in or about your home,
 - h. Prepare any meal, including setting the table, preparing food, cooking, or doing the dishes,
 - i. Make any bed in your home,
 - j. Leave your home for any reason except to visit your doctor's office,
 - k. Go for a drive in any motor vehicle,

- l. Operate a motor vehicle alone,
 - m. Attend any social gathering or entertainment outside your home,
 - n. Visit a store, market, shop, or other establishment, for the purpose of purchasing any item, including food, clothing, or merchandise.
5. Please describe the full extent of the effect of your disabilities on your ability to work, including
- a. Work on a part-time basis,
 - b. Work on a full-time basis,
 - c. Type of work performed,
 - d. Type of accommodations required.
6. Please indicate the cause of your disability including any effects of any injury, illness or birth defect.
7. Were you or are you now required to wear or use any support, cane, cast, brace, prosthesis, or other device or garment as a result of your disabilities?
8. If the answer to the preceding interrogatory is in the affirmative, please state:
- a. A full and complete description of such support, cane, cast, brace, prosthesis, or other device or garment,
 - b. The name and address of the person from whom purchased,
 - c. The cost thereof,
 - d. The period, giving inclusive dates, during which you were required to wear or use the same.

Need for Assistance to Live with Ailments or Disabilities.

1. Please identify all forms of assistance that you require to live with any disability you may have, including:
 - a. Special housing,
 - b. Modification to regular housing,
 - c. Caretakers and assistants,
 - d. Special equipment,
 - e. Customized vehicles,
 - f. Transportation,
 - g. Routine therapy,
 - h. Prosthesis,
 - i. Cane, brace, or other support device,
 - j. Other.
2. Please describe the limitations imposed by your disability with respect to activities of daily living.
3. Please identify the types of assistance you require for activities of daily living.
4. Please describe the limitations imposed by your disability with respect to social and recreational activities.
5. Please identify the types of assistance you require for social and recreational activities.

6. Please describe the limitations imposed by your disability with respect work and pursuing business related activities.
7. Please identify the types of assistance you require in order to work and pursue business related activities.