# HANFORD PERSONAL INJURY QUESTIONNAIRE

Please use other side of paper or additional sheets as necessary.

The following section is to be filled out with **your** information, if you are filling this out as a Personal Representative for another person, there is a space later in the questionnaire for their information. **Do not leave this section blank.**

TODAY'S DATE:_____

YOUR FULL NAME:_____ _____ _____
First Middle Last

ANY OTHER NAMES YOU'VE HAD (Maiden, Former Marriage, etc.)

_____

_____

YOUR CURRENT ADDRESS:_____
Street or P.O. Box

_____ _____ _____
City State/Prov. Zip Code

HOME TELEPHONE NUMBER: ____-____-_____

WORK OR DAYTIME NUMBER: ____-____-_____ FAX # OR E-MAIL ADD:_____

DATE OF BIRTH:_____

PLACE OF BIRTH:_____

SOCIAL SECURITY NUMBER: _____-_____-_____

NAME OF SPOUSE (Husbands, please include wife's maiden name):_____

DATE OF MARRIAGE:_____

NAMES OF FORMER SPOUSES (First and last names please) AND MARRIAGE DATES FOR EACH:

_____

HAVE YOU EVER FILED A LAWSUIT RELATED TO HANFORD AGAINST THE U.S. GOVERNMENT?

YES____ NO____ IF SO, DATE:_____ FILE OR DOCKET#_____

COURT LOCATION: _____

RESIDENCE LOCATIONS: Please list **ALL** places of residence you may have had from birth until present, please list each with the inclusive dates you resided there (e.g., Walla Walla, WA 1942-80). For each residence in Washington, Oregon, or Idaho, please indicate whether these places were near mountains, creeks, rivers, lakes, or valleys. We understand if you don't remember or don't know, but the more complete the information you give us, the better.

_____

_____

_____

_____

_____

_____

YOUR CHILDREN, FROM OLDEST TO YOUNGEST:

| Name | Date of Birth | Place of Birth | Natural/Adopted Stepchild |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

The following section is to be filled out **only** if you are acting as a Personal Representative or Guardian Ad Litem for another person. All sections below this section are to be filled out with the information pertinent to the claimant. If you are filling this form out for yourself then the reset of the information asked for in this questionnaire will be **yours**. If you are acting as Personal Representative or Guardian Ad Litem, the information will be about that **person you are representing**.

FULL NAME OF PERSON YOU ARE REPRESENTING: _____

NAMES BY WHICH THAT PERSON HAS OTHERWISE BEEN IDENTIFIED BY (MAIDEN, FORMER MARRIAGES)

_____

THEIR ADDRESS: _____
Street Suite/Apt. City State Zip

WHAT IS YOUR RELATIONSHIP TO HIM/HER? _____

THEIR SOCIAL SECURITY NUMBER: _____-_____-_____

THE FACTS WHICH YOU BELIEVE ENTITLE YOU TO REPRESENT THIS PERSON:

_____

_____

_____

_____

DATE AND PLACE OF BIRTH: _____

PLACES AT WHICH THIS PERSON RESIDED FROM BIRTH TO PRESENT (OR, IF APPLICABLE, TO THE TIME OF THE PERSON'S DEATH) AND INCLUSIVE DATES OF RESIDENCE:

_____

_____

_____

_____

IS HE/SHE DECEASED? YES _____ NO _____ CAUSE OF DEATH: _____

DATE AND PLACE OF DEATH: _____

AGE AT DEATH: _____ WAS AN AUTOPSY CONDUCTED? YES _____ NO _____
IF YES, LIST THE DATE AND PERFORMING PHYSICIAN:

_____

The following section is to be filled out with information pertinent to the claimant. If you are acting on your own behalf, use information regarding yourself. If you are acting as Personal Representative or Guardian Ad Litem, please use information regarding the person you requested.

**EDUCATIONAL HISTORY**

PLEASE LIST EACH SCHOOL YOU MAY HAVE ATTENDED (HIGH SCHOOL OR HIGHER)l

School Location Dates Diplomas/Degrees

_____

_____

_____

**MILITARY HISTORY**

HAVE YOU EVER SERVED IN THE MILITARY? YES _____ NO _____

BRANCH: _____ RANK:_____

SERIAL NO.: _____

PLACES YOU SERVED (BASES, FORTS, VESSELS, HOSPITALS, LABORATORIES, ETC.) AND INCLUSIVE DATES:

_____

_____

ANY MILITARY SERVICE AT HANFORD? YES _____ NO _____

DATES STATIONED THERE:_____

POSITION(S) HELD THERE:_____

DESCRIPTION OF DUTIES THERE: _____

_____

**EMPLOYMENT HISTORY**

(If you are self employed, please enter such and give position, title and job description).

CURRENT EMPLOYER:_____

ADDRESS:_____

POSITIONAL TITLE:_____

JOB DESCRIPTION:_____

DURATION OF EMPLOYMENT:_____

PREVIOUS EMPLOYER:_____

POSITIONAL TITLE:_____

JOB DESCRIPTION:_____

DURATION OF EMPLOYMENT:_____

HAVE YOU EVER WORKED AT HANFORD? YES _____ NO _____

EMPLOYER:_____

POSITION:_____

JOB DESCRIPTION:_____

DURATION OF EMPLOYMENT:_____

HAVE YOUR SPOUSE, CHILDREN, AND/OR PARENTS EVER WORKED AT HANFORD?
YES _____ NO _____

EMPLOYER:_____

POSITION:_____

JOB DESCRIPTION:_____

DURATION OF EMPLOYMENT:_____

## HEALTH AND ILLNESS HISTORY

HAVE YOU EVER BEEN ON THYROID MEDICATION? YES _____ NO _____

INCLUSIVE DATES:_____

Please mark the box next to any of the following illnesses that are applicable and list the date of diagnosis (if known) in the space provided.

## THYROID ILLNESSES

HAS A DOCTOR EVER TOLD YOU THAT YOUR HAVE:

| | | Date Diagnosed |
|---|---|---|
| GRAVES DISEASE | ( ) | _____ |
| HYPOTHYROIDISM | ( ) | _____ |
| THYROID NODULES | ( ) | _____ |
| HASHIMOTO'S | ( ) | _____ |
| THYROID CANCER | ( ) | _____ |
| HYPERTHYROIDISM | ( ) | _____ |
| DWARFISM | ( ) | _____ |
| GIGANTISM | ( ) | _____ |

OTHER THYROID PROBLEMS:_____

## CANCERS AND TUMORS

| | | Date Diagnosed |
|---|---|---|
| LUNG CANCER | ( ) | _____ |
| OVARIAN CANCER | ( ) | _____ |
| ESOPHAGAL CANCER | ( ) | _____ |
| INTESTINAL CANCER | ( ) | _____ |
| PANCREATIC CANCER | ( ) | _____ |
| BILE DUCT CANCER | ( ) | _____ |
| URINARY BLADDER CANCER | ( ) | _____ |
| BRAIN TUMOR | ( ) | _____ |
| MENINGIOMA | ( ) | _____ |
| LYMPHOMA | ( ) | _____ |
| BREAST CANCER | ( ) | _____ |
| PHARYNX CANCER | ( ) | _____ |
| STOMACH CANCER | ( ) | _____ |
| COLON CANCER | ( ) | _____ |

LIVER CANCER ( ) _____
GALL BLADDER CANCER ( ) _____
BRAIN CANCER ( ) _____
LEUKEMIA ( ) _____
MULT. MYELOMA ( ) _____
PROSTATE CANCER ( ) _____

OTHER TYPES OF CANCER_____

**OTHER DISEASES, DISORDERS, AND ILLNESSES**

| | | Date Diagnosed | |
|---|---|---|---|
| BONE MARROW DISEASES | ( ) | _____ | |
| RHEUMATOID ARTHRITIS | ( ) | _____ | |
| UNUSUAL OSTEOPOROSIS | ( ) | _____ | |
| MULTIPLESCLEROSIS | ( ) | _____ | |
| LUPUS | ( ) | _____ | |
| POLIO | ( ) | _____ | |
| TUBERCULOSIS | ( ) | _____ | |
| DIABETES | ( ) | _____ | |
| EYE DISORDERS | ( ) | _____ | |
| HEART DISEASES | ( ) | _____ | |
| BLOOD DISORDERS | ( ) | _____ | |
| AUTO-IMMUNE DISORDERS | ( ) | _____ | |
| RESPIRATORY DYSFUCTIONS | ( ) | _____ | |
| PSYCHIATRIC DISORDERS | ( ) | _____ | |
| SCARLATINA | ( ) | _____ | |
| UNUSUAL ITCHING/ BURNING OF SKIN | ( ) | _____ | |
| RHEMATIC FEVER | ( ) | _____ | |
| KIDNEY DISORDERS | ( ) | _____ | |
| ARTERY DISORDERS | ( ) | _____ | |
| CHRONIC FATIGUE | ( ) | _____ | |
| LYME DISEASE | ( ) | _____ | |
| SKIN DISORDERS | ( ) | _____ | |
| SUN INTOLERANCE | ( ) | _____ | |
| EXEMA | ( ) | _____ | |
| BONE DISEASES | ( ) | _____ | |
| ALLERGIES | ( ) | _____ | TYPES:_____ |

**REPRODUCTIVE PROBLEMS**

INFERTILITY ( )
STERILITY ( )
ENDEOMETRIOSIS ( )
MISCARRIAGES ( ) HOW MANY? ____ DATES:_____
STILLBIRTHS ( ) HOW MANY? ____ DATES:_____

DO YOU HAVE ANY OF YOUR MEDICAL RECORDS? YES_____ NO _____ IF SO, FROM WHICH ILLNESSES?_____

OTHER ILLNESSES OR COMMENTS ON MEDICAL HISTORY (UNUSUAL X-RAYS, LUMPS, TB, ENLARGED HEART); LOW RESISTANCE TO INFECTIONS (YEAST OR FUNGUS):

_____

_____

_____

**CHILDREN'S MEDICAL HISTORY**

ARE ANY OF YOUR CHILDREN DECEASED? YES _____ NO _____ CAUSE OF DEATH_____

WAS AN AUTOPSY PERFORMED? YES _____ NO _____

WERE YOU WELL INFORMED OF CHILD'S CONDITION?