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Darvocet/Darvon Questionnaire

Date: _____

Name: _____

Address: _____

Age: _____ Birth Date: _____ SSN: _____

Children: _____

Marital Status: _____ E-Mail: _____

Telephone: Daytime: _____ Evening: _____

Work: _____ Cell Phone: _____ Fax: _____

Email: _____

Name, Number & Address of Back up Contact Person?

Did you suffer any of the following adverse events while using Darvocet or Darvon:

Heart Attack	Y	N	Date: _____
Heart Rhythm Abnormalities	Y	N	Date: _____
Other	Y	N	Date: _____

Where you hospitalized as the result of any of the above? If so, please state when and where you were hospitalized. _____

When did you start taking Darvocet/Darvon? _____

When did you stop taking Darvocet/Darvon? _____

Name and address of the Physician who prescribed the Darvocet/Darvon:

Name and address of Pharmacy where prescription was filled: _____

Name the city and state where the script was written and filled?

Name the city and state where the adverse event took place if different than your current residence?

Have you ever had problems with your heart in the past? _____

Do you have a family history of heart problems? _____

When did you first learn that there was a problem with Darvocet or Darvon?

Have you ever filed bankruptcy or contemplating such: _____

Any Additional NOTES:
