QUESTIONNAIRE FOR HAIR RELAXER USERS

(If you are completing this questionnaire on behalf of another or someone who has passed away, please provide the information requested for the injured person)

Name: _____

Address: _____

_____

_____

E-mail Address: _____

Home Phone: _____ Work Phone: _____

Social Security # _____ - _____- _____ Date of Birth: # _____ - _____- _____

Employer: _____ Job Title: _____

Employer Address: _____

_____

_____

Marital Status: _____ Spouse's Name: _____

If deceased, please provide the date of death: _____

State of residence at the time of death: _____

Has an estate been opened: ☐ Yes ☐ No

If yes, please provide the name and contact information for the Administrator or Executor:

_____

_____

HAIR RELAXER USE

Salon Name and Address where hair relaxers were used, if applicable:

_____

_____

_____

Date Started Using Hair Relaxers: _____ Frequency per year:_____

Date Stopped Using Hair Relaxers: _____

Name and address of all stores where hair relaxers were purchased:

_____

_____

_____

_____

_____

_____

Which hair relaxer products did you use? Please check and/or list all products used.

Dark & Lovely ☐

Just for Me ☐

Soft & Beautiful ☐

Optimum Care ☐

Creme of Nature ☐

Motions ☐

ORS Olive Oil ☐

Other:

_____

_____

Did you ever use salon-grade hair relaxers? ☐ Yes ☐ No

Do you have any proof of purchase of hair relaxer products:

_____

_____

_____

_____

_____

Have you been diagnosed with any of the following:

Uterine Cancer Date of diagnosis _____

Endometrial Cancer Date of diagnosis _____

Ovarian Cancer Date of diagnosis _____

Uterine Fibroids Date of diagnosis _____

Other: _____ Date of diagnosis _____

Name of facility/physician who diagnosed you with the above conditions:

_____

_____

_____

Have you ever had any of the following procedures:

Myomectomy ☐ date _____

Hysterectomy ☐ date _____

Curettage ☐ date _____

Ablation ☐ date _____

Uterine artery embolization ☐ date _____

If you have been diagnosed with cancer, have you received chemotherapy and/or radiation treatment?

☐ Yes ☐ No

If yes, please indicate the following:

Date started radiation: _____

Date started chemotherapy: _____

Name and Address of facility where radiation and/or chemotherapy treatment was/is received:

_____

_____

_____

Have you been told you need a hysterectomy or myomectomy? ☐ Yes ☐ No

If yes, by whom:

_____

_____

Have you ever had a biopsy: ☐ Yes ☐ No

If you have, please indicate the following:
Date of biopsy: _____

Name and Address of where biopsy was done:

_____

_____

_____

Name and address of all hospitals where you received care related to hair relaxer use/cancer:

_____

_____

_____

Name and address of gynecologist or other physicians who treated you for any female reproductive health issues:

Current Physician(s) treating for Above Condition(s) (Provide Name and Address):

Did a doctor ever tell you that you were injured as a result of using hair relaxers:

☐ Yes ☐ No

If yes, when: _____

If you are completing this questionnaire on behalf of someone who died as a result of their use of hair relaxers, please provide the date of death, the cause of death and the name and address of any facility where medical services were rendered prior to the time of death :

Family Physician: (address & phone #):

Present Physician (address & phone #):

Identify any member of the health care profession who told you, or suggested to you, your injuries were the result of hair relaxer use.

On what date did you first become aware of the fact that your injuries may be the result of hair relaxer use? Explain:

If you completed this questionnaire on behalf of someone else, please provide your name, address, phone number, e-mail address and relationship to the individual injured (died) from hair relaxer use:

Date:

Signature

Printed Name of Signer