

Pfizer Consumer Healthcare
Pfizer Inc
201 Tabor Road
Morris Plains, NJ 07950
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Consumer Healthcare

June 08, 2006

Rusty Lucas
P.O. Box 422
Sandusky, OH 44871-0422

Dear Rusty Lucas:

This letter is in follow-up to your recent report regarding our product, Anusol (WI Usa)®. We are interested in obtaining additional medical information regarding your report. Please complete our adverse experience consumer questionnaire, which has been enclosed with an addressed, postage paid envelope.

Thank you for taking the time to share this information with us.

Sincerely,

Global Product Safety

Enclosures
File 2006069872 (0)
Ref 0004857852



Adverse Experience Consumer Questionnaire

Please complete the following questionnaire and return it in the enclosed postage-paid envelope. **PLEASE PRINT**

Today's Date: _____

Name of the person who had the adverse experience: _____

Address: _____

Daytime Telephone Number: _____

Date of Birth: _____ or Age: _____

Sex: M F Pregnant during treatment? No Yes If yes, weeks of gestation: _____

If different, your name and relationship to person described above: _____

Are you a health professional? No Yes If yes, please specify: _____

Product Name(s): _____

Manufacturer and lot numbers: _____ Expiration date(s): _____

Dosage form (eg., Caplet, Kapseal, Tablet, Liquid, Lotion, Cream, Spray): _____

Why did you use this product? _____

Dates of product use: From ___/___/___ to ___/___/___ or continuing?

How much and how often were you taking this product? _____

ADVERSE (UNDESIREABLE) EXPERIENCE

Describe the adverse experience you reported: _____

Date the adverse experience started: _____

Has it resolved? No Yes If yes, provide date: ___/___/___

Did you stop using the product? No Yes If yes, provide date: ___/___/___

If yes, did the adverse experience improve after discontinuing use of the product? No Yes , please describe:

If you stopped using the product, was it ever restarted? No Yes

If yes, did the same adverse experience occur? No Yes

Was the adverse experience treated with any medication? No Yes

If yes, please specify the name of the medication: _____

Please list any other present or past illnesses or medical problems:

Please list any known allergies including allergies to drugs. Describe what happens to you:

Please list any other medications taken during the time you were also taking our product. Include non-prescription drugs:

Medication Name	Reason for Use	Dates from/to
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Did you consult a health professional (doctor, nurse, pharmacist, etc.) because of the adverse experience?

No Yes by telephone _____ seen in person _____ Date: ____/____/____

Health Professional's name: _____
Address: _____
Telephone: _____

Were you seen in an emergency room because of the adverse experience? No Yes

Were you hospitalized because of the adverse experience? No Yes

If yes, specify date(s): _____

Hospital or Emergency Room Name: _____

Address: _____

Telephone Number: _____

Were medical or laboratory tests done because of the adverse experience (blood work, x-rays)? No Yes

If yes, please list the tests and results:

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

We would like to contact your physician or other health care person or medical facility who saw you for further details regarding your experience. May we have your permission for release of medical information to us? No Yes

Signature: _____ Date: ____/____/____

Your information is very important to us. Thank you for taking the time to complete this form.