

**ORTHOPAEDICS UNLIMITED**

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SPORTS MEDICINE - ARTHROSCOPIC SURGERY  
JOINT REPLACEMENT - SHOULDER & KNEE SPECIALIST

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Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Referred by: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

List Present Medications: \_\_\_\_\_

Are you pregnant? \_\_\_\_\_

Have you ever had the following disease or medical problems? Please answer each question.

Abnormal bleeding	Y	N	High Blood Pressure	Y	N
Alcohol/Drug Abuse	Y	N	HIV+/AIDS	Y	N
Arthritis	Y	N	Hospitalized	Y	N
Artificial Bones/Joints/Valves	Y	N	Kidney Problems	Y	N
Cancer/Chemotherapy	Y	N	Liver Diseases	Y	N
Congenital Heart Defect	Y	N	Low Blood Pressure	Y	N
Diabetes	Y	N	Mitral Valve Prolapse	Y	N
Emphysema	Y	N	Pacemaker	Y	N
Fainting Spells	Y	N	Psychiatric Problems	Y	N
Frequent Headaches	Y	N	Radiation Treatment	Y	N
Glaucoma	Y	N	Rheumatic/Scarlet Fever	Y	N
Hay Fever	Y	N	Shingles	Y	N
Heart Surgery	Y	N	Sickle Cell Disease	Y	N
Hemophilia	Y	N	Sinus Problems	Y	N
Hepatitis	Y	N	Stroke	Y	N
Herpes/Fever Blisters	Y	N	Thyroid Problems	Y	N
			Tuberculosis (TB)	Y	N

Are you allergic to any of the following?

Aspirin	Y	N	Penicillin	Y	N
Codeine	Y	N	Tetracycline	Y	N
Erythromycin	Y	N	Other	Y	N

Do you smoke?      Y      N                      How much? \_\_\_\_\_  
Do you drink alcoholic beverages?      Y      N      How much? \_\_\_\_\_

Past Surgeries/Operations \_\_\_\_\_

Family History:

Osteoporosis	Y	N	Kidney Stones	Y	N
Cancer	Y	N	Diabetes	Y	N
TB	Y	N	High Blood Pressure	Y	N

All of the questions have been answered completely and truthfully to the best of my knowledge.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Review \_\_\_\_\_