



DENTAL HYGIENE  
PATIENT MEDICAL HISTORY



CANDIDATE # \_\_\_\_\_

PATIENT'S FIRST NAME \_\_\_\_\_

DATE \_\_\_\_\_

**INSTRUCTIONS TO THE PATIENT:** Have you had or have you ever experienced any of the following conditions?  
Circle "YES" or "NO" to ALL questions.

<b>A</b>	Heart Condition	<b>YES</b>	<b>NO</b>	<b>H</b>	Diabetes	<b>YES</b>	<b>NO</b>
<b>B</b>	Heart Surgery	<b>YES</b>	<b>NO</b>	<b>I</b>	Tuberculosis	<b>YES</b>	<b>NO</b>
<b>C</b>	Valve Replacement	<b>YES</b>	<b>NO</b>	<b>J</b>	Kidney/Renal Disease	<b>YES</b>	<b>NO</b>
<b>D</b>	Stroke	<b>YES</b>	<b>NO</b>	<b>K</b>	Hepatitis/Jaundice	<b>YES</b>	<b>NO</b>
<b>E</b>	High Blood Pressure	<b>YES</b>	<b>NO</b>	<b>L</b>	HIV Positive	<b>YES</b>	<b>NO</b>
<b>F</b>	Bleeding Disorder	<b>YES</b>	<b>NO</b>	<b>M</b>	Epilepsy/Seizures	<b>YES</b>	<b>NO</b>
<b>G</b>	Asthma/Lung/Respiratory Condition(s)	<b>YES</b>	<b>NO</b>	<b>N</b>	Joint Replacement	<b>YES</b>	<b>NO</b>

Answer the following questions as completely and accurately as possible:

- Are you taking any medication, pills or drugs (prescribed or not)? **YES NO**  
If yes, please list: \_\_\_\_\_
- Do you have a known latex allergy or sensitivity to latex? **YES NO**  
If yes, please list: \_\_\_\_\_
- Are you allergic to any medicines? **YES NO**  
If yes, please list: \_\_\_\_\_
- Are you receiving or have you ever received intravenous bisphosphonates for bone cancer or severe osteoporosis? **YES NO**  
If yes, please list: \_\_\_\_\_
- Are you under the care of a physician at the present time or have you been treated by a physician in the past six months? **YES NO**  
If yes, for what condition: \_\_\_\_\_
- Do you have any disease or condition not listed above that we should know about? **YES NO**  
If yes, please list: \_\_\_\_\_
- Women only: Are you pregnant? **YES NO**  
If yes, expected due date: \_\_\_\_\_

Patient's Initials \_\_\_\_\_

**INSTRUCTIONS TO CANDIDATE**

Circle any "YES" answers in red pen. State in the lines below the significance (if any) and the steps taken for any alteration of procedure for this examination. Indicate the need and use for antibiotic prophylaxis, if necessary. Attach any verification of the patient's medical acceptability.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PATIENT BLOOD PRESSURE \_\_\_\_\_

PATIENT PULSE \_\_\_\_\_

CHIEF EXAMINER INITIALS \_\_\_\_\_

## PATIENT CONSENT FORM AND ASSUMPTION OF RISK

Western Regional Examining Board, an Arizona non-profit corporation ("WREB") is a national dental and dental hygiene testing agency required to test candidates' clinical skills for the states that accept the results of WREB exams. This involves doing certain types of dental procedures for volunteer patients. You have agreed to volunteer as a patient for a candidate (the "Candidate") that is taking a WREB exam.

The WREB examinations are typically administered at various dental or dental hygiene schools and universities ("School" or "Schools") around the country. Other than administering an examination at a School, WREB has no relationship or affiliation with any of the Schools.

The Candidate has met the educational requirements necessary to take the exam, but WREB has no knowledge regarding the Candidate's skill or competence. The Candidate who is treating you may not be licensed in any of the member states of WREB. The Candidate is performing the procedure(s) listed below for you as a part of the exam to determine if he/she is qualified to be licensed as a dentist or dental hygienist in a WREB state.

WREB does not assume any responsibility for the treatment you receive from the Candidate. If an injury or exposure to infectious agents occurs during the exam, neither WREB (including its examiners) nor the School assumes any responsibility to provide follow up care. WREB assumes no responsibility to notify you of any poor, substandard, or negligent work rendered by the Candidate. If you have any concerns regarding the quality of care administered by the Candidate, then you should see a licensed dentist or dental hygienist.

**You hereby expressly agree to assume the risk for an exposure or injuries of any kind that occur before, during, or after the WREB examination. You agree to indemnify WREB (including its examiners) against and hold WREB and its examiners harmless from any and all losses, claims, demands, damages, assessments, costs and expenses (including reasonable attorneys' fees) of every kind, nature or description resulting from, arising out of or relating to your health care or condition before, during, or after the examination.**

I hereby state that I have read and understand this Patient Consent Form and Assumption of Risk. I confirm that I am 18 years of age or older and that I am not a dentist, dental hygienist, dental or dental hygiene student. I hereby consent to the procedure(s) listed below. I realize that local anesthetics may have to be administered and I consent to the use of local anesthetics by the Candidate or other qualified practitioner. I consent to having the WREB examiners take intraoral photographs of my teeth and gums for use in future examiner calibrations, provided my name is not associated with the photographs in any way. Additionally, I authorize the use of my radiographs with the same provision of anonymity. I understand that my medical history on the reverse side will be shared with examiners as required to determine eligibility for the exam and for reference in case of medical emergency.

**I authorize Candidate ID # \_\_\_\_\_, to perform an oral assessment and calculus removal upon myself.**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\_\_\_\_\_  
Parent or Guardian's Signature  
(if patient is a minor)