Chapter 02
Introduction to Health Records

Multiple Choice Questions

1. What is the importance of health records?
A. They contain information crucial to patient care.
B. They contain roadmaps to a patient's health history.
C. They provide a clearer picture of the best route to take in future treatment of the patient.
D. All of these.
E. None of these.

Health records contain information crucial to patient care, are roadmaps to a patient's health history, and provide a clearer picture of the best route to take in future treatment of the patient.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.02
Topic: Types of Health Records

2. The first part of most medical notes that includes such information as medical history, duration and quality of the problem, and any exacerbating or relieving factors for that problem is known as the:
A. subjective.
B. objective.
C. assessment.
D. plan.
E. none of these.

The first part of most medical notes that includes such information as medical history, duration and quality of the problem, and any exacerbating or relieving factors for that problem is known as the subjective part of the note.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.01
Topic: The SOAP Method

3. Information such as the patient's physical exam, any laboratory findings, and imaging studies performed at the visit would be contained in which part of the diagnostic process?
A. Subjective
B. Objective
C. Assessment
D. Plan
E. None of these

Information such as the patient's physical exam, any laboratory findings, and imaging studies performed at the visit would be contained in the objective part of the diagnostic process.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.01
Topic: The SOAP Method

4. After a health care provider has gathered information from the patient and performed any necessary investigations, the health care provider then formulates a(n) _____, which could be a diagnosis, identification of the problem, or a differential diagnosis.
A. subjective
B. objective
C. assessment
D. plan
E. none of these

After a health care provider has gathered information from the patient and performed any necessary investigations (for example: physical exams, laboratory studies, or imaging studies), the health care provider then formulates an assessment, which could be a diagnosis, identification of the problem, or a differential diagnosis.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.01
Topic: The SOAP Method

5. The course of action consistent with a health care provider's assessment is known as a(n):
A. subjective.
B. objective.
C. assessment.
D. plan.
E. none of these.

The course of action consistent with a health care provider’s assessment is known as a plan.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.01
Topic: The SOAP Method

6. Which of the following is FALSE about the SOAP method?
A. Diagnostic work in medicine is very similar to the investigative work of a detective; thus the SOAP method begins with an analysis and ends with collecting data to confirm the diagnosis.
B. Most medical notes share a consistent pattern in their organization and layout that reflects the SOAP thought process.
C. SOAP is an acronym that stands for Subjective, Objective, Assessment, and Plan.
D. SOAP reflects a general thought process used by most medical professionals.
E. The SOAP method is repeated in every health care visit across all disciplines of medicine.

Diagnostic work in medicine begins with data collection and concludes with an analysis.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.01
Topic: The SOAP Method

7. The story of the patient's problem is known as:
A. chief complaint.
B. family history.
C. history of present illness.
D. review of history.
E. social history.

The story of the patient’s problem is known as the history of present illness.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.02
Topic: Types of Health Records

8. A *review of systems* is:
A. a description of individual body systems in order to discover any symptoms not directly related to the main problem.
B. a record of habits like smoking, drinking, drug abuse, and sexual practices that can impact health.
C. any significant illnesses that run in the patient's family.
D. other significant past illnesses, like high blood pressure, asthma, or diabetes.
E. the story of the patient's problem.

A *review of systems* is a description of individual body systems in order to discover any symptoms not directly related to the main problem.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.02
Topic: Types of Health Records

9. Which section of the health record is NOT included in the subjective section?
A. Chief complaint
B. Family history
C. Past medical history
D. Review of systems
E. Social history

The chief complaint as well as the family, past medical, and social histories are all part of the subjective (the patient’s personal story of his or her health issues).

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.01
Learning Outcome: 02.02
Topic: The SOAP Method
Topic: Types of Health Records

10. Which of the following health records would NOT include a plan?
A. Clinic note
B. Consult note
C. Emergency department note
D. Pathology report
E. Prescription

A pathology report provides a reason for the test, what was on the test, and an assessment.

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.02
Topic: Types of Health Records

11. Which of the following notes is usually authored by a specialist and provides an expert opinion on a more challenging problem?
A. Admission summary
B. Clinic note
C. Consult note
D. Daily hospital/progress note
E. Emergency department note

A consult note is usually authored by a specialist and provides an expert opinion on a more challenging problem.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.02
Topic: Types of Health Records

12. Which of the following health care notes is NOT usually authored in a hospital?
A. Admission summary
B. Clinic note
C. Daily hospital/progress note
D. Discharge summary
E. Emergency department note

An admission summary, a daily hospital/progress note, a discharge summary, and an emergency department note are usually authored in a hospital. A clinic note is most often authored in a clinic.

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.02
Topic: Types of Health Records

13. Which of the following health records describes when and why a patient was admitted to the hospital, documents his/her stay in the hospital, and indicates the type of follow-up the patient will have?
A. Admission summary
B. Clinic note
C. Daily hospital/progress note
D. Discharge summary
E. Emergency department note

A discharge summary describes when and why a patient was admitted to the hospital, documents his/her stay in the hospital, and indicates the type of follow-up the patient will have.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.02
Topic: Types of Health Records

14. Which of the following pairs of terms are opposites?
A. Acute, abrupt
B. Exacerbation, symptom
C. Febrile, afebrile
D. Genetic, hereditary
E. Lethargic, malaise

Febrile means to have a fever. Afebrile means the patient does not have a fever.

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

15. A patient concern that just started recently, or is a sudden onset, severe symptom, is called:
A. acute.
B. chronic.
C. febrile.
D. lethargic.
E. noncontributory.

A patient concern that just started recently, or is a sudden onset, severe symptom, is called acute.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

16. If a patient's symptoms or disease is becoming more and more severe, evident, etc. each day, it is known as:
A. abrupt.
B. acute.
C. genetic.
D. malaise.
E. progressive.

If a patient's symptoms or disease is becoming more and more severe, evident, etc. each day, it is known as progressive.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

17. Which of the following is the correct definition for the term *symptom*?
A. All of a sudden
B. It has been going on for a while now.
C. It runs in the family.
D. Not feeling well
E. Something a patient feels

A symptom is something a patient feels.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

18. Which of the following is the correct definition for the term *chronic*?
A. All of a sudden
B. It has been going on for a while now.
C. It runs in the family.
D. Not feeling well
E. Something a patient feels

Chronic means that it has been going on for a while now.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

19. A patient complains of itchy skin and has a very noticeable rash. What is an appropriate medical term to describe the rash?
A. Alert
B. Marked
C. Objective
D. Oriented
E. Unremarkable

Marked means that it really stands out.

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

20. A patient has *unremarkable* symptoms. *Unremarkable* is a medical term used to mean:
A. it stands out.
B. normal.
C. responsive.
D. unresponsive.
E. none of these.

Unremarkable is another way of saying normal.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

21. During a patient exam, a medical professional may feel parts of the patient's body. This is called:
A. auscultation.
B. diagnosing.
C. palpation.
D. palpitation.
E. percussion.

Palpation means "to feel."

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

22. Which of the following is the best definition for differential diagnosis?
A. A list of conditions the patient may have based on the symptoms exhibited and the results of the exam
B. A problem resulting from a disease or injury
C. Another way of saying assessment
D. The cause
E. What the health care professional thinks the patient has

A differential diagnosis is a list of conditions the patient may have based on the symptoms exhibited and the results of the exam.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

23. The risk for being sick is known as:
A. malignant.
B. morbidity.
C. mortality.
D. prognosis.
E. remission.

The risk for being sick is known as morbidity.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

24. A systemic infection by definition:
A. stays in a certain part of the body.
B. infects all or most of the body.
C. is a dangerous problem.
D. is a problem resulting from disease or injury.
E. is the organism that caused the problem.

A systemic infection infects all or most of the body.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

25. The term *pathogen* comes from combining the roots *path/o* and *gen/o*. Which are the correct root and term definitions?
A. *path/o* (development, nourishment) + *gen/o* (generation, cause) = *pathogen* (development or nourishment of the cause)
B. *path/o* (development, nourishment) + *gen/o* (suffering, disease) = *pathogen* (development or nourishment of the suffering/disease)
C. *path/o* (generation, cause) + *gen/o* (suffering, disease) = *pathogen* (generation/cause of the suffering/disease)
D. *path/o* (suffering, disease) + *gen/o* (development, nourishment) = *pathogen* (development or nourishment of the suffering/disease)
E. *path/o* (suffering, disease) + *gen/o* (generation, cause) = *pathogen* (generation/cause of the suffering/disease)

The correct root and term definitions are *path/o* (suffering, disease) + *gen/o* (generation, cause) = *pathogen* (generation/cause of the suffering/disease).

Accessibility: Keyboard Navigation
Blooms: Create
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

26. When a medical professional gives a *prognosis*, he is indicating:
A. the chances for things getting better or worse.
B. the organism that causes the problem.
C. the risk for being sick.
D. the risk for dying.
E. what he thinks the patient has.

When a medical professional gives a *prognosis*, he/she is indicating the chances for things getting better or worse.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

27. Which of the following is FALSE about the term *discharge*?
A. It can mean *to send home*.
B. It is included as part of the "plan" section in a health care note.
C. It literally means *to unload*.
D. It can mean that the patient has been cured.
E. It refers to a fluid coming out of a part of the body.

Just because a patient has been *discharged* does not mean he/she has been cured.

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

28. *Prophylaxis* refers to:
A. extremely clean, germ-free conditions.
B. observation of a patient.
C. preventative treatment.
D. telling the patient that the problem is not serious or dangerous.
E. treating the symptoms but not actually getting rid of the cause.

Prophylaxis is preventative treatment.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

29. In order to treat the symptoms and make the patient feel better, a medical professional may recommend:
A. discharge.
B. observation.
C. prophylactic medication.
D. reassurance.
E. supportive care.

In order to treat the symptoms and make the patient feel better, a medical professional may recommend supportive care.

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

30. Which of the following terms is part of a patient's assessment?
A. Auscultation
B. Family medical history
C. Past surgical history
D. Reassurance
E. Sequelae

Sequelae are problems resulting from disease or injury. They are included as part of a patient's diagnosis.

Accessibility: Keyboard Navigation
Blooms: Apply
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

31. Which is the correct opposite for the *proximal* part of the body?
A. Distal
B. Dorsum
C. Ipsilateral
D. Prone
E. Ventral

Proximal means closer in to the center. *Distal* means farther away from the center.

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

32. Which of the following does NOT refer to "the front"?
A. Antral
B. Anterior
C. Dorsal
D. Ventral
E. They all refer to "the front."

Dorsal refers to the back.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

33. If a patient is *prone*, he is:
A. lying down on his belly.
B. lying down on his back.
C. lying down on his left side.
D. lying down on his right side.
E. standing.

If a patient is *prone*, he is lying down on his belly.

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

34. When a person uses her left hand to reach to the right, she is showing _____ movement.
A. bilateral
B. contralateral
C. ipsilateral
D. lateral
E. unilateral

Contralateral refers to the opposite side.

Accessibility: Keyboard Navigation
Blooms: Apply
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

35. A scan of the body divides the body in slices from left to right.
A. coronal
B. ipsilateral
C. sagittal
D. supine
E. transverse

A sagittal scan of the body divides the body in slices from left to right.

Accessibility: Keyboard Navigation
Blooms: Apply
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

36. Which of the following is NOT an abbreviation that refers to a health care facility or department?
A. CTA
B. ECU
C. ER
D. OR
E. PACU

CTA means "clear to auscultation."

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

37. A PACU is a(n):
A. care unit for cardiac patients.
B. intensive care unit for children.
C. intensive care unit for patients.
D. postanesthesia care unit.
E. recovery room following an operation.

PACU means "postanesthesia care unit." A PICU is a pediatric intensive care unit.

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

38. Which term refers to "before surgery"?
A. L&D
B. OR
C. PACU
D. Post-op
E. Pre-op

Pre-op means "before surgery."

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

39. A patient usually has surgery in a(n):
A. ED.
B. ICU.
C. OR.
D. PACU.
E. SICU.

A patient has surgery in an OR (operating room).

Accessibility: Keyboard Navigation
Blooms: Apply
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

40. A CC is usually included on which part of the health care record?
A. Subjective
B. Objective
C. Assessment
D. Plan
E. None of these

CC stands for "chief complaint" and is usually part of the subjective section of a health record.

Accessibility: Keyboard Navigation
Blooms: Apply
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.02
Learning Outcome: 02.04
Topic: Abbreviations
Topic: Types of Health Records

41. When a patient is examined by a medical professional, which of the following would NOT be part of the physical examination?
A. BP
B. Hx
C. T
D. VS
E. Wt

Hx is the abbreviation meaning "history" and is not usually included in the physical examination.

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

42. What is the correct definition for the abbreviation RR?
A. Radiology report
B. Rapid rate
C. Recurrent reason
D. Respiratory rate
E. Responsive remission

RR means "respiratory rate."

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

43. The amount of fluids a patient has taken in and produced is abbreviated:
A. BMI.
B. H&P.
C. HPI.
D. I/O.
E. PERRLA.

I/O stands for input/output and refers to the amount of fluids a patient has taken in and produced.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

44. Which of the following abbreviations is NOT part of a patient's history (either medical history or history of the illness)?
A. H&P
B. HPI
C. h/o
D. PMHx
E. CTA

CTA means "clear to auscultation" and is part of the objective portion of a patient's health record.

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

45. Interpret the following abbreviations: "The Pt is 5y/o."
A. The patient is 5 years old.
B. The patient is 5 years under observation.
C. The prescription is 5 years old.
D. The prescription is 5 years under observation.
E. None of these.

Pt is the abbreviation for "patient"; y/o is the abbreviation for "years old." The patient is 5 years old.

Accessibility: Keyboard Navigation
Blooms: Apply
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

46. PCP refers to the:
A. past care provider.
B. primary care provider.
C. past complaint or problem.
D. present complaint or problem.
E. primary complaint or problem.

PCP refers to the primary care provider.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

47. A discharge summary will often have information regarding the recommended f/u, or _____ for the patient.
A. future ultrasounds
B. future ultrasonographies
C. future uses
D. following ultrasounds
E. follow up

The abbreviation for follow-up is f/u.

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

48. PERRLA means:
A. pathogen is emerging, responsive, and responsive to adversity.
B. patient is equalized, recovering, responsive, and adjusting.
C. physical exam has been reported, responded to, and accepted by insurance.
D. pupils are equal, round, and reactive to light and accommodation.

PERRLA means "pupils are equal, round, and reactive to light and accommodation."

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

49. Which of the following would NOT describe a patient with a normal physical exam?
A. CTA, RRR
B. CTA, SOB
C. NAD, WDWN
D. PERRLA, A&O
E. WNL

SOB stands for shortness of breath.

Accessibility: Keyboard Navigation
Blooms: Apply
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

50. NOS and NEC are:
A. abbreviations used for symptoms and exam findings.
B. catchalls for diagnoses that don't quite fit any specific cause.
C. mean "not otherwise specified" or "not elsewhere classified."
D. all of these.
E. none of these.

NOS and NEC are abbreviations used for symptoms and exam findings, mean "not otherwise specified" or "not elsewhere classified," and are catchalls for diagnoses that don’t quite fit any specific cause.

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

51. Which of the following is true about the abbreviation CTA?
A. Means "clear to auscultation"
B. Describes normal-sounding lungs
C. Is an abbreviation used by medical professionals after listening (*auscultation* = "listen")
D. All of these
E. None of these

CTA means "clear to auscultation," describes normal-sounding lungs, and is an abbreviation used by medical professionals after listening.

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.03
Learning Outcome: 02.04
Topic: Abbreviations
Topic: Common Terms on Health Records

52. The normal blood pressure range is 90/60 to 140/90. A patient's blood pressure has been documented at 120/80. Which of the following abbreviations describes the patient's blood pressure?
A. BP NAD
B. BP NEC
C. BP RRR
D. BP WDWN
E. BP WNL

BP (blood pressure) is WNL (within normal limits).

Accessibility: Keyboard Navigation
Blooms: Evaluate
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

53. After a car accident, the medical professional asks the patient questions about her name, location, and the date. The patient is able to accurately answer all of the questions. The patient can be classified as:
A. A&O.
B. PERRLA.
C. NAD.
D. ROS.
E. WDWN.

The patient is alert (able to answer questions, responsive, interactive) and oriented (aware of who she is, where she is, and the current time). The correct abbreviation for this is A&O.

Accessibility: Keyboard Navigation
Blooms: Apply
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations
Topic: Common Terms on Health Records

54. Which of the following pairs of abbreviations are opposites?
A. IM, IV
B. IV, CVL
C. NPO, PR
D. PO, NPO
E. SC, IM

PO means "by mouth"; NPO means "nothing by mouth."

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

55. Which of the following is an accurate breakdown of the abbreviation SC?
A. *signa* care = *signa* (label) + care = carefully labeled
B. *subcutaneous* = *sub* (above) + *cutane/o* (skin) = above the skin
C. *subcutaneous* = *sub* (beneath) + *cutane/o* (skin) = beneath the skin
D. *subcutaneous* = *sub* (through) + *cutane/o*(muscle) = through the muscle
E. supportive care (abbreviation comes from regularly used English words)

SC means *subcutaneous* = *sub* (beneath) + *cutane/o* (skin) = beneath the skin.

Accessibility: Keyboard Navigation
Blooms: Analyze
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

56. A medicine administered PR is given in the:
A. lungs (respirated).
B. mouth.
C. rectum.
D. skin.
E. vein.

PR means "per rectum."

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

57. Which is the correct abbreviation for a medicine administered "as desired"?
A. Ad lib
B. IM
C. NPO
D. PICC
E. PO

Ad lib means "as desired."

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

58. A medication prescribed BID is taken:
A. once a day.
B. twice a day.
C. three times a day.
D. before meals.
E. after meals.

BID means "two in a day."

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

59. Which abbreviation does NOT describe the time of day in which a prescription should be taken?
A. AC
B. PC
C. am
D. QHS
E. TID

TID means "three times a day."

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

60. The prescriber uses which of the following abbreviations if a medication is to be taken before meals?
A. AC
B. PC
C. prn
D. QHS
E. TID

AC is from the Latin phrase *ante cibum*, which means "before food."

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

61. Which of the following abbreviations would most likely be found in the "plan" portion of a health record?
A. Dx
B. PERRLA
C. QHS
D. ROS
E. RRR

QHS means "at the hour of sleep" and is an abbreviation used on prescriptions. Prescriptions are part of a patient’s treatment plan.

Accessibility: Keyboard Navigation
Blooms: Analyze
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations
Topic: The SOAP Method

62. Which of the following is an accurate breakdown of the abbreviation IM?
A. instrumental = the essential portions of a patient's health record
B. *intermedical* = *inter* (between) + *medic/o* (medicine) + *al (pertaining to)* = information shared between medical professionals
C. *intramicrobial* = *intra* (in, inside) + *micro* (small) + *bial* (pertaining to) = pertaining to the small microorganisms for which a prescription is dedicated
D. *intramuscular* = *intra* (in, inside) + *muscul/o* (muscle) + *ar* (pertaining to) = inside a muscle
E. None of these

IM means *intramuscular* = *intra* (in, inside) + *muscul/o* (muscle) + *ar* (pertaining to) = inside a muscle. Learning Outcome 02.03

Accessibility: Keyboard Navigation
Blooms: Create
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations
Topic: Common Terms on Health Records

63. The following is an excerpt from a patient's medical record. According to this information, which is NOT true about the patient?

T: 98.5; HR: 60; RR: 20; BP: 112/70.

General: Pleasant, responsive. No acute distress.

HEENT: PERRLA. Mucous membranes moist and pink.

Resp: CTA. No wheezes, rales, rhonchi, or crackles. Good air exchange. No increased work of breathing.

A. The patient is afebrile.
B. The patient is alert.
C. The patient's eyes are not reacting to light.
D. The patient's heart rate is 60.
E. The patient's respiratory rate is 20.

PERRLA means the patient's pupils are equal, round, and reactive to light and accommodation.

Accessibility: Keyboard Navigation
Blooms: Analyze
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.04
Learning Outcome: 02.05
Topic: Abbreviations
Topic: Common Terms on Health Records
Topic: Electronic Health Records

64. Which part of the SOAP method most accurately describes the following excerpt from a patient's clinic note?

T: 99.0; HR: 60; RR: 20; BP: 112/70.

General: Pleasant, responsive. No acute distress.

HEENT: PERRLA. Mucous membranes moist and pink.

Resp: CTA. No wheezes, rales, rhonchi, or crackles. Good air exchange. No increased work of breathing.

A. Subjective
B. Objective
C. Assessment
D. Plan
E. Prescription

This information is part of the patient's physical exam, which is the objective part of the SOAP method.

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.05
Topic: Electronic Health Records
Topic: The SOAP Method

65. The following is an excerpt from a consult note.

PMHx:

CAD with PTCA in 20xx.Hypertension.Hypertriglyceridemia.

Medications: Beta blocker, nitroglycerin prn, ASA, antilipidemic agent.

Allergies: Penicillin.

FHx: Brother deceased from an MI at 69 years of age.

SHx: Patient does not smoke. He drinks 1-2 beers per week. Denies illicit drug use. He is married with two grown children and three grandchildren.

This information is most accurately classified as:
A. review of systems.
B. past surgical history.
C. patient history.
D. prescription plans.
E. treatment plan.

PMHx (past medical history), FHx (family medical history), and SHx (social history) are all part of a patient's medical history.

Accessibility: Keyboard Navigation
Blooms: Apply
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.05
Topic: Abbreviations
Topic: Electronic Health Records

66. A patient was given a prescription with the following information: "Sig. 5 mL PO BID x 10 days." Which is the most accurate description of the patient prescription?
A. The medication will be taken as needed for ten days.
B. The medication will be taken by mouth once a day for ten days.
C. The medication will be taken by mouth twice a day for ten days.
D. The medication will be taken intravenously for ten days.
E. The medication will be taken subcutaneously for ten days.

The medication will be taken by mouth (PO) twice a day (BID) for ten days (x10 days).

Accessibility: Keyboard Navigation
Blooms: Apply
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.05
Topic: Abbreviations
Topic: Electronic Health Records

67. In the following prescription, which line gives the patient instructions?

Amoxicillin 400 mg/5ml

Sig. 5 ml PO BID x 10days

Dispense 100ml

Refills: None

Brand name medically necessary

A. Amoxicillin 400 mg/5ml
B. Sig. 5 ml PO BID x 10days
C. Dispense 100ml
D. Refills: None
E. Brand name medically necessary

The second line, marked "Sig.", contains the patient's instructions.

Accessibility: Keyboard Navigation
Blooms: Analyze
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.05
Topic: Abbreviations
Topic: Electronic Health Records

68. Which of the following abbreviations and terms is NOT associated with the assessment in the SOAP method?
A. DDx
B. Idiopathic
C. Mortality
D. Occult
E. WDWN

WDWN stands for "well-developed, well-nourished" and is part of exam findings (observation).

Accessibility: Keyboard Navigation
Blooms: Apply
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations
Topic: Common Terms on Health Records
Topic: The SOAP Method

69. If a patient's infection is classified as *occult*, it is:
A. dangerous.
B. getting better.
C. getting worse.
D. hidden.
E. without a known or specific cause.

Occult means "hidden."

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

70. If a patient's infection is classified as *malignant*, it is:
A. dangerous.
B. getting better.
C. getting worse.
D. hidden.
E. without a known or specific cause.

Malignant means "dangerous."

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

71. The *cause* is also called the:
A. diagnosis.
B. etiology.
C. impression.
D. remission.
E. sequelae.

Etiology means "the cause."

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

72. If an infection stays in a certain part of the body, it is:
A. degenerate.
B. localized.
C. malignant.
D. recurrent.
E. systemic.

Localized means that it stays in a certain part of the body.

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

73. A symptom that a patient has again and that continues to get worse is called:
A. degenerate; malignant.
B. recurrent; degenerate.
C. recurrent; idiopathic.
D. idiopathic; malignant.
E. malignant; recurrent.

Recurrent means "to have again"; d*egenerate* means "getting worse."

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

74. According to the following discharge summary, which is true about this patient?

HPI

Mrs. Roxana Collach presented to the ED with a 2-day history of increasing epigastric pain. She described the pain as constant and dull with radiation to her back. She also had progressive anorexia. She denied nausea, emesis, or diarrhea. She was febrile in the ED and had marked epigastric tenderness on exam with guarding. Her abdomen was slightly distended and she was mildly jaundiced. Her elevated amylase and lipase confirmed the suspicion of acute pancreatitis. She was admitted for pain control and IVF.

A. Her anorexia was getting better.
B. Her anorexia was getting better.Her anorexia was getting better.
C. She did not have any epigastric tenderness.
D. She was diagnosed with pancreatitis.
E. She was not given intravenous fluids.

Her elevated amylase and lipase confirmed. . .pancreatitis.

Accessibility: Keyboard Navigation
Blooms: Analyze
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.05
Topic: Abbreviations
Topic: Common Terms on Health Records
Topic: Electronic Health Records

75. According to the following discharge summary, which of the following is NOT true about this patient?

Discharge Physical Examination

Temp: 98.6; RR: 24; HR: 86; BP: 100/64.

Gen: WDWN. Alert.

CV: RRR.

Resp: CTA.

GI: Abdomen soft, nondistended, mild tenderness to palpation over the surgical incisions. Three small horizontal surgical wounds in her abdomen. Wounds clean, dry, and intact.

Activity

No restrictions.

A. The patient does not have a fever.
B. The patient experiences mild tenderness when her surgical incisions are touched.
C. The patient's heart is beating rapidly.
D. The patient looks well-developed and well-nourished.
E. The patient's lungs sound clear.

RRR refers to "regular rate and rhythm" of the heart.

Accessibility: Keyboard Navigation
Blooms: Analyze
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.05
Topic: Abbreviations
Topic: Common Terms on Health Records
Topic: Electronic Health Records

76. Which of the abbreviations would be a correct reflection of the following Emergency Department note?

Physical Exam

Vital Signs: Temperature: 102.3; Heart Rate: 90; Respiratory Rate: 20;BP: 112/84.

General: Well-developed and nourished, in mild discomfort. Alert andoriented x 3.

A. Vital Signs: T: 90; HR: 90; RRR; BP: 112/84

General: WDWN, in mild discomfort. A&Ox3

B. Vital Signs: T: 102.3; HR: 90; RR: 20; BP: 112/84

General: WDWN, in mild discomfort. A&Ox3

C. Vital Signs: T: 102.3; HR: 90; RR: 20; BP: 112/84

General: WW, in mild discomfort. A&Ox3

D. Vital Signs: T: 102.3; HtR: 90; RR: 20; BldPres: 112/84

General: WW, in mild discomfort. A&Ox3

E. Vital Signs: Temp: 102.3; HtR: 90; RR: 20; BP: 112/84

General: WW, in mild discomfort. Al&Orx3

Vital Signs: Temperature (T): 102.3; Heart Rate (HR): 90; Respiratory Rate (RR): 20; Blood Pressure (BP): 112/84. General: Well-developed, well-nourished (WDWN); in mild discomfort. Alert and oriented (A&O) x3.

Accessibility: Keyboard Navigation
Blooms: Create
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.05
Topic: Abbreviations
Topic: Common Terms on Health Records
Topic: Electronic Health Records

77. From which portion of a consult note is the following excerpt?

Reason for Consult: urinary retention

HPI: Mr. Johnson is a 57-year-old male with a 2-month history of difficulty voiding. He reports urgency and frequency. He has had increasing problems with a weakurinary stream. The symptoms have progressed to include mild abdominal discomfortand erectile dysfunction. He denies any incontinence, hematuria, balanorrhea, orchiodynia, or trauma. He has not tried any medicines at this point.

PMHx: Hypercholesterolemia-currently controlled with diet. Positive history of gonococcalurethritis 3 years previously. No history of urolithiasis.

A. Subjective
B. Objective
C. Assessment
D. Plan
E. Prescription

This is the subjective portion of the consult note.

Accessibility: Keyboard Navigation
Blooms: Apply
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.05
Topic: Electronic Health Records
Topic: The SOAP Method

78. Which is a correct interpretation of the following portion of a physical exam?

CV: RRR without murmur, gallops, or rubs.

Resp: CTA bilaterally.

A. Heart has a regular rate and rhythm; lungs are clear on both sides.
B. Heart has a regular rate and rhythm; right lung is clear.
C. Heart rate is normal; lungs are cloudy on both sides.
D. Heart rate is slightly elevated; lungs are clear on both sides.
E. Heart rhythm is normal; left lung is cloudy.

Heart has a regular rate and rhythm (RRR) and lungs are clear to auscultation (CTA) bilaterally (on both sides).

Accessibility: Keyboard Navigation
Blooms: Analyze
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations
Topic: Common Terms on Health Records

79. The following is an excerpt from a patient's discharge summary. Which of the following is NOT true about this excerpt?

HPI

Miss Susan Nesbit is a 12-year-old female who first visited her primary care provider for dysuria. A UA was ordered, but the patient could not urinate in the office. She took the UA cup home but did not return with the sample. The next day, Susan's dysuria worsened, and she developed a fever of 102.3^{o} F, as well as vomiting and hematuria, so she returned to the clinic. A urinalysis performed in the office revealed significant pyuria, hematuria, and albuminuria. Since Susan was not able to keep any fluids down, her primary care provider sent her to the emergency department for evaluation for admission.

A. Her PCP sent her to the ED for evaluation and admission.
B. It contains the history of the present illness.
C. The patient is 12 y/o.
D. The patient returned to the clinic when her dysuria worsened and she became febrile.
E. The patient went to the ED before seeing her PCP.

The patient first visited her primary care physician (PCP) before going to the emergency department (ED).

Accessibility: Keyboard Navigation
Blooms: Analyze
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.05
Topic: Abbreviations
Topic: Common Terms on Health Records
Topic: Electronic Health Records

80. The following excerpt is from which portion of the discharge summary?

Labs

Admission labs: UA: Pyuria: .20 wbcs; Hematuria: 3 1 blood; Albuminuria: 1 1 protein.

Urine culture: *E. coli.*

Blood culture: *E. coli.*

Discharge labs: UA normal. Urine culture normal.

Imaging

VCUG: No vesicoureteral reflux noted.

RUS: No hydronephrosisnoted. Normal.

Spiral CT of kidneys on day 3 of admission revealed perinephric abscess formation of the left kidney.

A. Subjective
B. Objective
C. Assessment
D. Plan
E. Prescription

Labs and imaging are part of the objective portion of the SOAP method.

Accessibility: Keyboard Navigation
Blooms: Analyze
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.02
Topic: The SOAP Method
Topic: Types of Health Records

81. The following excerpt would most accurately be classified as which kind of health care record?

Dear Dr. Childs,

Thank you for referring Mr. Samuels to my office. I saw him on March 3, 2015. Mr. Samuels has a 4-month history of increasing pain in his right distal femur. He first noticed pain after being kicked in the leg at a soccer game and was evaluated in your office 3 weeks later for persistent pain. There was a soft tissue mass in his distal femur that was tender to touch.

A. Consult note
B. Operative report
C. Pathology report
D. Prescription
E. Discharge summary

A consult note provides an expert opinion on a more challenging problem and can be in the form of a letter to the primary care physician.

Accessibility: Keyboard Navigation
Blooms: Analyze
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.05
Topic: Common Terms on Health Records
Topic: Electronic Health Records

82. According to the following discharge summary, which of the following statements is NOT true?

Hospital Course

On postop day 2, Ms. Cloud began complaining of increasing right ophthalmalgia. She was noted to be febrile to 102.2. Exam revealed conjunctival infection and edema. She was presumed to have postoperative endophthalmitis. Vitrectomy was performed under sterile conditions, and samples were sent to lab for culture. She was given intravitreal antibiotics. Over the next couple of days, her fever curve trended down and her WBC count improved. Cultures came back positive for *S. epidermidis.* Infectious disease was consulted; they recommended two weeks of IV therapy. A PICC line was placed and she was discharged with care instructions.

A. A peripherally inserted central catheter was inserted.
B. Ms. Cloud complained of increasing right ophthalmalgia 2 days before her surgery.
C. Ms. Cloud developed a fever while in the hospital.
D. Ms. Cloud was presumed to have endophthalmitis after her operation.
E. The vitrectomy was performed under extremely clean, germ-free conditions.

Ms. Cloud complained of increasing right ophthalmalgia on postop (after surgery) day 2.

Accessibility: Keyboard Navigation
Blooms: Analyze
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.05
Topic: Abbreviations
Topic: Common Terms on Health Records
Topic: Electronic Health Records

83. According to the following discharge summary, Ms. Cloud began complaining of ophthalmalgia.

Hospital Course

On postop day 2, Ms. Cloud began complaining of increasing right ophthalmalgia. She was noted to be febrile to 102.2. Exam revealed conjunctival infection and edema. She was presumed to have postoperative endophthalmitis. Vitrectomy was performed under sterile conditions, and samples were sent to lab for culture. She was given intravitreal antibiotics. Over the next couple of days, her fever curve trended down and her WBC count improved. Cultures came back positive for S. epidermidis. Infectious disease was consulted; they recommended two weeks of IV therapy. A PICC line was placed and she was discharged with care instructions.

Which is the correct definition of the suffix -algia?
A. Cause
B. Hernia
C. Medical science
D. Pain
E. Specialist

-*algia* is the suffix meaning "pain."

Accessibility: Keyboard Navigation
Blooms: Remember
Difficulty: 1 Easy
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Electronic Health Records

84. Read this excerpt from a patient's health record.

PMHx

Johnny's history is significant for tympanostomy tubes placed bilaterally when he was 2 years old. One tube left a persistent perforation in the tympanic membrane, so he had tympanoplasty at 3 years of age. He has not had any episodes of otitis media in the past 2 years.

This is the patient's:
A. chief complaint.
B. history of present illness.
C. past medical history.
D. personal social medical history.
E. review of systems.

PMHx stands for "past medical history."

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.05
Topic: Common Terms on Health Records
Topic: Electronic Health Records

85. The patient had "tubes placed bilaterally."

PMHx

Johnny's history is significant for tympanostomy tubes placed bilaterally when he was 2 years old. One tube left a persistent perforation in the tympanic membrane, so he had tympanoplasty at 3 years of age. He has not had any episodes of otitis media in the past 2 years.

Which is the correct breakdown and definition of the term *bilateral*?
A. *bi* (one) + *lateral* (out to the side) = one side
B. *bi* (side) + *lateral* (toward the middle) = toward the middle of the side
C. *bi* (side) + *lateral* (toward the side) = toward the side
D. *bi* (two) + *lateral* (out to the side) = both sides
E. *bi* (two) + *lateral* (toward the middle) = in the middle

Bilateral breaks down into *bi* (two) + *lateral* (out to the side) = both sides.

Accessibility: Keyboard Navigation
Blooms: Apply
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

86. The following excerpt most likely comes from what time of health record?

Emergency Department Course:

Miss Sweet arrived in the ED lethargic but responsive. Given her history and vomiting, we were concerned about diabetic ketoacidosis. The patient's finger stick blood sugar test result of 320 confirmed hyperglycemia, and a urinalysis revealed both glucosuria and ketonuria. An IV was started and labs were sent. Chemistry profile showed hypernatremia, hypokalemia, and acidemia. The pediatric intensive care team was contacted for transfer to the PICU.

Disposition: Transfer to PICU.

A. Clinic note
B. Emergency department note
C. Operative report
D. Pathology report
E. Radiology report

The excerpt is from an emergency department note.

Accessibility: Keyboard Navigation
Blooms: Apply
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.05
Topic: Electronic Health Records
Topic: Types of Health Records

87. In the following health record, the patient's *disposition* is noted.

Emergency Department Course:

Miss Sweet arrived in the ED lethargic but responsive. Given her history and vomiting, we were concerned about diabetic ketoacidosis. The patient's finger stick blood sugar test result of 320 confirmed hyperglycemia, and a urinalysis revealed both glucosuria and ketonuria. An IV was started and labs were sent. Chemistry profile showed hypernatremia, hypokalemia, and acidemia. The pediatric intensive care team was contacted for transfer to the PICU.

Disposition: Transfer to PICU.

The correct definition for *disposition* in this context is:
A. how the patient is feeling.
B. the main reason for the patient's visit.
C. what happened to the patient at the end of the visit.
D. when the patient will be sent home.
E. none of these.

Disposition in this context refers to what happened to the patient at the end of the visit.

Accessibility: Keyboard Navigation
Blooms: Apply
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

88. Read the following health record excerpt.

Emergency Department Course:

Miss Sweet arrived in the ED lethargic but responsive. Given her history and vomiting, we were concerned about diabetic ketoacidosis. The patient's finger stick blood sugar test result of 320 confirmed hyperglycemia, and a urinalysis revealed both glucosuria and ketonuria. An IV was started and labs were sent. Chemistry profile showed hypernatremia, hypokalemia, and acidemia. The pediatric intensive care team was contacted for transfer to the PICU.

Disposition: Transfer to PICU.

According to this excerpt, when Miss Sweet arrived at the ED, she was:
A. A&O x3.
B. did not look very sick and was able to answer questions and interact with health care professionals.
C. did not look very sick but acted very sick.
D. looked sick and was unable to answer questions or interact with health care professionals.
E. looked sick but was alert.

A *lethargic* patient has a decrease in level of consciousness; it is a general indication that the patient is really sick. *Alert* is a medical term that means a patient is able to answer questions and is responsive; interactive.

Accessibility: Keyboard Navigation
Blooms: Apply
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.05
Topic: Common Terms on Health Records
Topic: Electronic Health Records

89. Read the following health record excerpt:

Emergency Department Course:

Miss Sweet arrived in the ED lethargic, but responsive. Given her history and vomiting, we were concerned about diabetic ketoacidosis. The patient's finger stick blood sugar test result of 320 confirmed hyperglycemia, and a urinalysis revealed both glucosuria and ketonuria. An IV was started and labs were sent. Chemistry profile showed hypernatremia, hypokalemia, and acidemia. The pediatric intensive care team was contacted for transfer to the PICU.

Disposition: Transfer to PICU.

According to this excerpt, Miss Sweet was transferred to the:
A. emergency department.
B. laboratory.
C. pathology.
D. pediatric intensive care unit.
E. postanesthesia care unit.

Miss Sweet was transferred to the pediatric intensive care unit.

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.04
Topic: Abbreviations

90. In order for the medical professional to perform a physical examination, he asked the patient to lie down on his back. The patient is lying _____.
A. caudally
B. dorsum
C. prone
D. proximally
E. supine

Supine means "lying down on the back."

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

91. Your belly button is located on the _____ part of your body.
A. anterior, lateral
B. anterior, medial
C. dorsal, lateral
D. dorsal, medial
E. lateral, medial

Your belly button is located on the anterior (the front) and medial (toward the middle) part of your body.

Accessibility: Keyboard Navigation
Blooms: Apply
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

92. The inferior vena cava is also known as the posterior vena cava. From the terms *inferior* and *posterior*, one can say that this vein is _____ the heart on the _____ side.
A. above, back
B. above, front
C. below, back
D. below, front

Inferior means "below"; *posterior* means "the back."

Accessibility: Keyboard Navigation
Blooms: Apply
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

93. The superior vena cava is a large-diameter, yet short, vein that carries deoxygenated blood from the body to the heart . It is located in the *anterior* right *superior* mediastinum. The correct definitions of *anterior* and *superior* are:
A. back, above.
B. back, below.
C. front, above.
D. front, below.

Anterior means "the front"; *superior* means "above."

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

94. A patient has a rash on the top of both of his hands. Which is the correct medical term for the rash's location?
A. Bilateral, dorsum
B. Bilateral, palmar
C. Bilateral, plantar
D. Unilateral, dorsum
E. Unilateral, palmar

Dorsum refers to the top of the hand or foot.*Bilateral* means "both sides."

Accessibility: Keyboard Navigation
Blooms: Analyze
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

95. If a person's head were divided on the coronal plane, which of the following is NOT true?

A. The division would be from front to back, and therefore both eyes could be seen on the same plane.
B. The division would be from front to back, and therefore only one eye would be seen at a time.
C. The division would be from left to right,and therefore both eyes could be seen on the same plane.
D. The division would be from left to right,and therefore only one eye would be seen at a time.

The *coronal* plan divides the body in slices from front to back. Since both eyes are on the front of the head, they could be seen on the same coronal plane.

Accessibility: Keyboard Navigation
Blooms: Analyze
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

96. As part of a patient's treatment plan, she was admitted to the hospital for observation. This means:
A. the patient needs to be admitted to the hospital to undergo further tests before she can be diagnosed.
B. the patient will be discharged with a prescription.
C. the patient will be in the hospital so that medical professionals can watch, or keep an eye on, her.
D. the patient will be sent home to see if the symptoms get better on their own.
E. the patient's symptoms resolved after her hospital stay.

Observation in this context means "to watch or keep an eye on."

Accessibility: Keyboard Navigation
Blooms: Apply
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records

97. Read the following discharge summary:

Hospital Course

Mrs. Collach was admitted to the medical service. She was placed on NPO status and given IVF and analgesics. An ultrasound revealed gallstones in the common bile duct as the etiology for Mrs. Collach's pancreatitis. Surgery was consulted. On hospital day 2, Mrs. Collach was taken to the OR for laparoscopic choledocholithectomy and cholecystectomy. She tolerated the procedure well. She began a postoperative refeeding plan with a low-protein, low-fat diet. She tolerated advancing the diet, and 2 days after her surgery, her pain had improved enough that she was discharged home.

According to this summary, which of the following is true?
A. Mrs. Collach could eat a low-protein, low-fat diet when she was first admitted to the hospital.
B. Mrs. Collach spent some time in the intensive care unit.
C. Mrs. Collach was given palliative care throughout her hospital stay.
D. Mrs. Collach was given a low-protein, low-fat diet before her operation.
E. Mrs. Collach was not allowed to have anything by mouth and was given intravenous fluids when she was first admitted to the hospital.

Mrs. Collach was placed on NPO (*nil per os* = nothing by mouth) status and given IVF (intravenous fluids) and analgesics.

Accessibility: Keyboard Navigation
Blooms: Analyze
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.05
Topic: Abbreviations
Topic: Common Terms on Health Records
Topic: Electronic Health Records

98. Read the following discharge summary:

Hospital Course

Mrs. Collach was admitted to the medical service. She was placed on NPO status and given IVF and analgesics. An ultrasound revealed gallstones in the common bile duct as the etiology for Mrs. Collach's pancreatitis. Surgery was consulted. On hospital day 2, Mrs. Collach was taken to the OR for laparoscopic choledocholithectomy and cholecystectomy. She tolerated the procedure well. She began a postoperative refeeding plan with a low-protein, low-fat diet. She tolerated advancing the diet, and 2 days after her surgery, her pain had improved enough that she was discharged home.

According to this summary, which of the following is true?

A. The ultrasound results are pending.
B. The ultrasound revealed gallstones, and the cause of the pancreatitis is occult.
C. The ultrasound revealed gallstones as the cause of Mrs. Collach's pancreas pain.
D. The ultrasound revealed gallstones, but they were noncontributory.
E. The ultrasound revealed the common bile duct has lesions.

The ultrasound revealed gallstones as the etiology (cause) of Mrs. Collach's pancreas pain.

Accessibility: Keyboard Navigation
Blooms: Apply
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.05
Topic: Abbreviations
Topic: Electronic Health Records

99. The following is a portion of a patient's consult note:

Past Medical History: Noncontributory.

Past Surgical History: Balanoplastyfor hypospadias at age 1.

Social History: Doug lives with his parents and older sister. He is going into kindergarten in the fall.

Family History: Paternal grandfather with polycystic kidney disease.

According to the doctor who authored this note, which of the following is true?
A. The patient has never had any surgeries
B. The patient has polycystic kidney disease.
C. The patient is 10 y/o.
D. The patient's PMHx is not related to this specific problem.
E. There is not enough information to draw any conclusions.

The patient's past medical history (PMHx) is noncontributory (not related to this specific problem).

Accessibility: Keyboard Navigation
Blooms: Analyze
Difficulty: 3 Hard
Est Time: 0-1 minute
Learning Outcome: 02.05
Topic: Abbreviations
Topic: Common Terms on Health Records
Topic: Electronic Health Records

100. Which of the following is NOT true about the medical term remission?
A. It is a term that a medical professional might use in the assessment part of the health record.
B. It means the illness has been cured.
C. It means "to get better or improve."
D. It is most often used when discussing cancer.
E. None of these.

Remission does not mean cure.

Accessibility: Keyboard Navigation
Blooms: Understand
Difficulty: 2 Medium
Est Time: 0-1 minute
Learning Outcome: 02.03
Topic: Common Terms on Health Records