Bonewit: Clinical Procedures for Medical Assistants, 8th Edition

Chapter 1: The Medical Record

Test Bank

CAAHEP Cognitive (Knowledge Base)

IV. Concepts of Effective Communication:

6. Differentiate between subjective and objective information
9. Discuss applications of electronic technology in effective communication
11. Define both medical terms and abbreviations related to all body systems
12. Organize technical information and summaries

V. Administrative Functions:

5. Identify systems for organizing medical records
6. Describe various types of content maintained in a patient's medical record
8. Identify both equipment and supplies needed for filing medical recrods
11. Discuss principles of using Electronic Medical Record (EMR)
12. Identify types of records common to the health care setting

IX. Legal Implications:

1. Explore issue of confidentiality as it applies to the medical assistant
3. Describe the implications of HIPAA for the medical assistant in various medical settings
13. Discuss all levels of governmental legislation and regulation as they apply to medical assisting practice, including FDA and DEA regulations

ABHES Content Competencies

3. Medical Terminology:

a. Basic structure of medical words
b. Word element combinations
d. Medical abbreviations

4. Medical Law and Ethics:

a. Documentation
b. Federal and state guidelines
c. Established policies
f. Health laws and regulations

6. Pharmacology:

g. Records for medications and immunizations

8. Medical Office Business Procedures/ Management:

b. Medical records
y. Effective communication

9. Medical Office Clinical Procedures:

a. Patient history

MULTIPLE CHOICE

Directions: Choose the best answer.
Each question is worth 1.5 points.

1. What information is contained in the medical record?
   a. Health history
   b. Results of the physical examination
   c. Laboratory reports
   d. Progress notes
   e. All of the above

   ANS: E

2. Which of the following is *not* a function of the medical record?
   a. To provide information for making decisions regarding the patient's care
   b. To document the patient's progress
   c. To serve as a legal document
   d. To share information between members of the patient's family

   ANS: D

3. The purpose of HIPAA is to
   a. Reduce exposure of patients to bloodborne pathogens
   b. Provide patients with more control over the use and disclosure of their health information
   c. Prevent the patient's records from being copied
   d. Encourage the patient to become more involved in preventive health care

   ANS: B

4. The patient registration record consists of
   a. Demographic and billing information
   b. Medication instructions given to the patient
   c. The results of the physical examination
   d. A list of problems associated with the patient's illness
   e. All of the above

   ANS: A

5. All of the following are included in the patient registration record *except*
   a. Date of birth
   b. Allergies
   c. Employer
   d. Patient's insurance company

   ANS: B

6. Which of the following provides subjective data about a patient to assist the physician in arriving at a diagnosis?
   a. Laboratory tests
   b. Physical examination
   c. Health history
   d. Diagnostic tests

   ANS: C

7. Which of the following is *not* included on a medication record for medication administered at the office?
   a. Name of the medication
   b. Route of administration
   c. Dosage administered
   d. Number of refills

   ANS: D

8. A narrative report of an opinion about a patient's condition by a practitioner other than the attending physician is known as a
   a. Correspondence report
   b. Discharge summary report
   c. Consultation report
   d. Health history report

   ANS: C

9. Which of the following services may be provided through home health care?
   a. IV therapy
   b. Respiratory care
   c. Rehabilitation
   d. Maternal-child care
   e. All of the above

   ANS: E

10. A report of the analysis of body specimens is known as a
    a. Therapeutic report
    b. Diagnostic report
    c. Laboratory report
    d. Progress report

    ANS: C

11. All of the following are examples of diagnostic reports *except*
    a. Urinalysis report
    b. Spirometry report
    c. Colonoscopy report
    d. Radiology report

ANS: A

12. All of the following are examples of physical therapy *except*
    a. Electrical stimulation
    b. Hydrotherapy
    c. Therapeutic exercise
    d. Breathing treatments

    ANS: D

13. Which of the following helps a patient with a disability learn new skills to perform the activities of daily living?
    a. Speech therapy
    b. Occupational therapy
    c. Physical therapy
    d. Dietitian

    ANS: B

14. What term is used to describe a patient who has been admitted to the hospital for at least one overnight stay?
    a. Outpatient
    b. Ambulatory patient
    c. Guest
    d. Inpatient

    ANS: D

15. Conclusions drawn from an interpretation of data are known as
    a. Medical impressions
    b. Prognosis
    c. Symptoms
    d. Charting'

    ANS: A

16. All of the following are included in an operative report *except*
    a. The name of the surgical procedure
    b. Description of the procedure used during surgery
    c. Prognosis
    d. Postoperative diagnosis

    ANS: C

17. Which of the following reports consists of an account of the significant events of a patient’s hospitalization?
    a. Emergency department report
    b. Pathology report

c. History and physical report
d. Discharge summary report

ANS: D

18. Which of the following reports consists of a macroscopic and microscopic description of tissue removed during surgery?
a. Laboratory report
b. Pathology report
c. Diagnostic imaging report
d. Operative report

ANS: B

19. A copy of the patient's emergency department report is sent to the
a. Patient's insurance company
b. Patient
c. Patient's family physician
d. Laboratory

ANS: C

20. A consent to treatment form is required for
a. Tuberculin skin testing
b. Sebaceous cyst removal
c. Ear irrigation
d. Blood pressure measurement

ANS: B

21. Which of the following must be included in informed consent?
a. An explanation of risks involved with the procedure
b. Any alternative treatments or procedures available
c. The prognosis
d. The purpose of the recommended procedure
e. All of the above

ANS: E

22. When a medical assistant witnesses a patient's signature, it means that he or she
a. Verified the patient's identity and watched the patient sign the form
b. Verified that the information on the form is correct
c. Verified that the patient is aware of the risks involved with the procedure to be performed
d. Verified that the physician discussed informed consent with the patient

ANS: A

23. Which of the following situations requires the completion of a release of medical information form?
    a. When a patient transfers records to a new physician
    b. To bill the patient's insurance company
    c. To send the patient's records to a consulting physician
    d. To determine the patient's eligibility for insurance benefits

    ANS: A

24. All of the following are included on a release of medical information form *except*
    a. The specific information to be released
    b. The need for the information
    c. The patient's signature
    d. The expiration date of the release form
    e. Medications being taken by the patient

    ANS: E

25. Which of the following can be performed by an electronic medical record software program?
    a. Creation of a medical record
    b. Storage of a medical record
    c. Editing of a medical record
    d. Retrieval of a medical record
    e. All of the above

    ANS: E

26. All of the following are advantages of an electronic medical record (EMR) *except*
    a. An EMR does not have to be filed.
    b. Documents in an EMR can be quickly retrieved.
    c. More than one person can view an EMR at the same time.
    d. EMRs are exempt from the HIPAA regulations.

    ANS: D

27. How are paper documents entered into a patient's electronic medical record?
    a. By scanning them into the computer
    b. By retyping them on the computer
    c. By photocopying them
    d. By transmitting them through a modem

    ANS: A

28. Which of the following are used to enter data into an electronic medical record?
    a. Free-text entry
    b. Drop-down lists
    c. Check boxes
    d. All of the above

ANS: D

29. In a source-oriented record, a radiology report is filed under which of the following chart dividers?
    a. History and Physical
    b. Progress Notes
    c. Lab/X-ray
    d. Hospital

    ANS: C

30. With reverse chronological order, the most recent document is
    a. Filed alphabetically
    b. Filed by subject title
    c. Placed in front of the other documents
    d. Placed in back of the other documents

    ANS: C

31. All of the following are included in the database section of a POR *except*
    a. Health history report
    b. Physical examination report
    c. Baseline laboratory test results
    d. Plan of treatment

    ANS: D

32. The acronym for the format used to organize POR progress notes is
    a. SOAP
    b. TGIF
    c. OSHA
    d. PPR

    ANS: A

33. Data obtained from the patient are recorded in POR progress notes under
    a. Subjective data
    b. Objective data
    c. Assessment
    d. Plan

    ANS: A

34. The physician's interpretation of the patient's condition is recorded in POR progress notes under
    a. Subjective data
    b. Objective data
    c. Assessment

d. Plan

ANS: C

35. The purpose of the tab on a file folder is to
    a. Hold documents in place in the folder
    b. Identify the contents of the folder
    c. Prevent the folder from being misfiled
    d. Keep the folder closed when not in use

    ANS: B

36. All of the following assist in the collection of data for a health history *except*
    a. A quiet, comfortable room
    b. Showing interest in the patient
    c. Showing concern for the patient
    d. Calling the patient "honey"

    ANS: D

37. Which of the following can be used to enter a health history into an electronic medical record?
    a. The patient completes a paper form and the medical assistant scans it into the computer
    b. The medical assistant enters information while asking the patient questions
    c. The patient completes a health history on a computer
    d. All of the above

    ANS: D

38. The health history is taken
    a. After the physician performs the physical examination
    b. After laboratory test results are reviewed
    c. Before the physician performs the physical examination
    d. After the physician makes a diagnosis of the patient's condition

    ANS: C

39. What is the chief complaint?
    a. The probable outcome of the patient's condition
    b. The symptom causing the patient the most trouble
    c. A detailed description of the patient's illness using medical terms
    d. A tentative diagnosis of the patient's condition

    ANS: B

40. Which of the following questions should be used to elicit the chief complaint from a patient?
    a. Where does it hurt?

b. Are you sick?
c. How long have you been ill?
d. What seems to be the problem?
e. All of the above

ANS: D

41. Which of the following is a correct example for recording the chief complaint?
a. "Complains of pain in the left shoulder."
b. "The patient does not feel well today."
c. "Burning in the chest and coughing for the past 2 days."
d. "Otitis media that began following a cold."

ANS: C

42. An expansion of the chief complaint is known as the
a. Review of systems
b. Present illness
c. Progress report
d. Provisional diagnosis

ANS: B

43. What is the medical history?
a. The patient's previous diseases, injuries, and operations
b. The symptom causing the patient the most trouble
c. Information about the patient's lifestyle
d. The hereditary diseases and health of blood relatives

ANS: A

44. All of the following are included in the medical history *except*
a. Accidents and injuries
b. Immunizations
c. Operations
d. Medications
e. Occupation

ANS: E

45. A review of the health status of blood relatives is known as
a. Family history
b. Review of systems
c. Genetic review
d. Chronological history

ANS: A

46. Which of the following is an example of a familial disease?

a. Tuberculosis
b. Pneumonia
c. Diabetes mellitus
d. Emphysema

ANS: C

47. The social history is important, because the following may affect the patient's condition:
a. Lifestyle
b. Familial diseases
c. Past injuries
d. Medications being taken by the patient

ANS: A

48. All of the following are included in the social history *except*
a. Dietary history
b. Health habits
c. Occupation
d. Chronic illnesses

ANS: D

49. What is the ROS?
a. A history of the patient's previous diseases, injuries, and operations
b. The symptom causing the patient the most trouble
c. A systematic review of each body system
d. A review of the hereditary diseases and health of blood relatives

ANS: C

50. What term is used to describe the process of making written entries about a patient in the medical record?
a. Charting
b. Registration
c. Scribbling
d. Documentation

ANS: A

51. Black ink should be used when recording in the patient's chart to
a. Provide a permanent record
b. Ensure legible handwriting
c. Avoid spelling errors
d. Reduce charting errors

ANS: A

52. All of the following must be done when charting *except*

a. Begin each new entry on a separate line
b. Include the patient's name at the beginning of each entry
c. Begin each phrase with a capital letter
d. Include the date and time with each entry

ANS: B

53. A procedure should be charted immediately after being performed to
a. Avoid charting the procedure out of sequence
b. Avoid performing the wrong procedure on a patient
c. Avoid forgetting certain aspects of the procedure
d. Prevent another staff member from charting the procedure

ANS: C

54. Which of the following is the correct way to sign a charting entry?
a. D.B., CMA (AAMA)
b. Dawn C. Bennett, CMA (AAMA)
c. D. Bennett, CMA (AAMA)
d. Bennett, CMA (AAMA)

ANS: C

55. Why should a recording in the medical record never be erased or obliterated?
a. It makes it harder to read the chart.
b. The patient may not receive the proper care.
c. Credibility is reduced if the physician is involved in litigation.
d. It indicates the procedure was performed incorrectly.

ANS: C

56. The purpose of progress notes is to
a. Provide a review of each body system
b. Update the medical record with new patient information
c. Prevent the patient's condition from getting worse
d. Ensure that the patient returns for follow-up care

ANS: B

57. What is a symptom?
a. Conclusions drawn from an interpretation of data
b. Any change in the body or its functioning that indicates disease
c. The probable outcome of a disease
d. The scientific method of identifying a patient's condition

ANS: B

58. What is an objective symptom?
a. A symptom that can be observed by another person

b. A symptom that precedes a disease
c. A symptom that is felt by the patient and cannot be observed by another
d. The symptom causing the patient the most trouble

ANS: A

59. Which of the following is an example of a subjective symptom?
a. Rash
b. Pain
c. Dyspnea
d. Bleeding

ANS: B

60. Laboratory tests ordered on a patient at an outside laboratory should be charted to provide documentation in case the following occurs:
a. The patient does not undergo the test.
b. The test results are abnormal.
c. The patient's condition gets worse.
d. The test results are negative.

ANS: B

61. Why is it important to document any instructions provided to the patient?
a. To ensure that the patient understands the instructions provided
b. To protect the physician legally if the patient is harmed by not following the instructions
c. To ensure that the patient follows the instructions
d. To provide a record for the insurance company

ANS: B

62. Flushed skin usually indicates
a. The patient is experiencing pain
b. An elevated temperature
c. The patient has chills
d. The patient has a rash

ANS: B

63. A yellow color of the skin that is first observed in the whites of the eyes is called
a. Cyanosis
b. Hepatitis
c. Pallor
d. Jaundice

ANS: D

64. A decrease in the amount of water in the body is known as

a. Edema
b. Acidosis
c. Epistaxis
d. Dehydration

ANS: D

65. What term is used to describe excessive perspiration?
a. Dehydration
b. Diaphoresis
c. Edema
d. Hyperemesis

ANS: B

66. What term is used to describe dizziness?
a. Epistaxis
b. Vertigo
c. Urticaria
d. Pruritus

ANS: B