MULTIPLE CHOICE

1. 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 REF: p. 2| CAAHEP Competency (2015): VI.4
   OBJ: 1

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

   ANS: E REF: pp. 2-3| CAAHEP Competency (2015): VI.4
   OBJ: 2

3. The purpose of the HIPAA Privacy Rule is to
   a. reduce exposure of patients to bloodborne pathogens.
   b. provide patients with better 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 REF: p. 4 | CAAHEP Competency (2015): IX.3
   OBJ: 2

4. All of the following are characteristics of the Notice of Privacy Practices *except*:
   a. Was developed by the American Medical Association
   b. Must explain how a patient's health information will be used and protected by the medical office
   c. Must be provided to each patient
   d. Must obtain a signed acknowledgment from the patient that he/she has received an NPP

   ANS: A REF: p. 4| CAAHEP Competency (2015): IX.3
   OBJ: 2

5. Health information in any form that contains patient identifiable information is known as
   a. PHI.
   b. NPP.
   c. OSHA.
   d. HIPAA.

   ANS: A REF: p. 4| CAAHEP Competency (2015): IX.3
   OBJ: 2

6. In which of the following situations does HIPAA *not* require written consent for the use or disclosure of protected health information?
   a. Patient referral to a specialist
   b. Emergency care provided at a hospital
   c. Determination of eligibility for insurance benefits
   d. Training of health care students
   e. All of the above

   ANS: E REF: p. 4| CAAHEP Competency (2015): IX.3
   OBJ: 2

7. Which of the following is *not* an example of a medical office clinical document?
   a. Patient registration record
   b. Physical examination report
   c. Medication record
   d. Health history report

   ANS: A REF: pp. 2-3| CAAHEP Competency (2015): VI.4
   OBJ: 2

8. Which of the following is *not* a characteristic of a laboratory report?
   a. It relays results of laboratory tests to the provider
   b. It consists of a report of the analysis or examination of body specimens
   c. It assists in diagnosing and treating disease
   d. It is a request for laboratory tests to be performed by an outside laboratory

   ANS: D REF: pp. 2-3| CAAHEP Competency (2015): VI.4
   OBJ: 2

9. Which of the following is an example of a diagnostic procedure report?
   a. Electrocardiogram report
   b. Physical therapy report
   c. Urinalysis report
   d. Pathology report

   ANS: A REF: pp. 2-3| CAAHEP Competency (2015): VI.4
   OBJ: 2

10. What is the name of the type of report that documents the assessments and treatments designed to restore a patient's ability to function?
    a. Consultation report
    b. Diagnostic procedure report
    c. Pathology report
    d. Therapeutic service report

    ANS: D REF: pp. 2-3| CAAHEP Competency (2015): VI.4
    OBJ: 2

11. Which of the following is *not* an example of a hospital report?
    a. Operative report
    b. Cytology report
    c. Discharge summary report
    d. Emergency department report

    ANS: B REF: pp. 2-3| CAAHEP Competency (2015): VI.4
    OBJ: 2

12. Which of the following is an example of a consent document?
    a. Patient registration record
    b. Notice of Privacy Practices form
    c. Release of medical information form
    d. Patient instruction sheet

    ANS: C REF: pp. 2-3| CAAHEP Competency (2015): VI.4
    OBJ: 2

13. 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 REF: p. 3| CAAHEP Competency (2015): V.8
    OBJ: 3

14. 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 REF: pp. 3, 6| CAAHEP Competency (2015): VI.12
    OBJ: 5

15. Which of the following are used to enter data into an electronic medical record?
    a. Free-text entry
    b. Drop-down menus
    c. Radio buttons
    d. All of the above

    ANS: D REF: p. 11| CAAHEP Competency (2015): V.8
    OBJ: 8

16. 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 REF: p. 11| CAAHEP Competency (2015): VI.4
    OBJ: 8

17. What is the name of a program that converts typed text into text that can be manipulated by the computer (once it has been scanned into the computer)?
    a. POMR
    b. OCR
    c. Word processing program
    d. Practice management program

    ANS: B REF: p. 6| CAAHEP Competency (2015): VI.12
    OBJ: 4

18. 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 REF: p. 6| CAAHEP Competency (2015): V.3.
    OBJ: 8

19. 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 into the computer while asking the patient questions.
    c. The patient completes a health history questionnaire on a computer.
    d. All of the above

    ANS: D REF: p. 6| CAAHEP Competency (2015): IX.12
    OBJ: 8

20. What is a health history?
    a. A legal document required to perform certain procedures on a patient
    b. Documentation of the results of the physical examination
    c. A collection of subjective data about the patient
    d. A narrative description and interpretation of a diagnostic procedure

    ANS: C REF: p. 6| CAAHEP Competency (2015): V.10
    OBJ: 6

21. The health history is taken
    a. after the provider performs the physical examination.
    b. after laboratory test results are reviewed.
    c. before the provider performs the physical examination.
    d. after the provider makes a diagnosis of the patient’s condition.

    ANS: C REF: p. 6| CAAHEP Competency (2015): VI.4
    OBJ: 6

22. 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 REF: p. 7| CAAHEP Competency (2015): V.10
    OBJ: 7

23. 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 REF: p. 7| CAAHEP Competency (2015): V.1
    OBJ: 7

24. Which of the following is a correct example for documenting 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 REF: p. 7| CAAHEP Competency (2015): V.7
    OBJ: 7

25. 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 REF: p. 7| CAAHEP Competency (2015): V.10
    OBJ: 7

26. What is the past 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 REF: pp. 7, 11| CAAHEP Competency (2015): V.10
    OBJ: 6

27. All of the following are included in the past medical history *except*
    a. accidents and injuries.
    b. immunizations.
    c. hospitalizations and operations.
    d. current medications.
    e. occupation.

    ANS: E REF: pp. 7, 11| CAAHEP Competency (2015): VI.4
    OBJ: 6

28. 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 REF: p. 11| CAAHEP Competency (2015): VI.4
    OBJ: 6

29. Which of the following is an example of a familial disease?
    a. Tuberculosis
    b. Pneumonia
    c. Diabetes mellitus
    d. Emphysema

    ANS: C REF: p. 11| CAAHEP Competency (2015): V.10
    OBJ: 6

30. The social history focuses on which of the following that may affect the patient's condition?
    a. Patient's lifestyle
    b. Familial diseases
    c. Past injuries
    d. Medications being taken by the patient

    ANS: A REF: p. 11| CAAHEP Competency (2015): VI.4
    OBJ: 6

31. All of the following are included in the social history *except*
    a. dietary history.
    b. health habits.
    c. occupation.
    d. chronic illnesses.

    ANS: D REF: p. 11| CAAHEP Competency (2015): VI.4
    OBJ: 6

32. 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 REF: p. 11| CAAHEP Competency (2015): V.10
    OBJ: 6

33. What term is used to describe the process of recording information about a patient in the medical record?
    a. Documenting
    b. Registration
    c. Scribbling
    d. Classifying

    ANS: A REF: p. 11| CAAHEP Competency (2015): V.10
    OBJ: 8

34. All of the following must be performed when documenting in the medical record *except:*
    a. Check the name on the medical record before making an entry.
    b. Include the patient's name at the beginning of each entry.
    c. Begin each phrase with a capital letter and end with a period.
    d. Never document for someone else.

    ANS: B REF: pp. 11-12 | CAAHEP Competency (2015): V.7
    OBJ: 8

35. A procedure should be documented immediately after being performed to
    a. avoid documenting 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 documenting the procedure.

    ANS: C REF: pp. 11-12| CAAHEP Competency (2015): I.12
    OBJ: 8

36. Black ink should be used when documenting in the PPR to
    a. provide a permanent record.
    b. ensure legible handwriting.
    c. avoid spelling errors.
    d. reduce documentation errors.

    ANS: A REF: pp. 11-12| CAAHEP Competency (2015): I.12
    OBJ: 8

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

    ANS: C REF: pp. 11-12| CAAHEP Competency (2015): VI.4
    OBJ: 8

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

    ANS: C REF: pp. 11-12| CAAHEP Competency (2015): I.12
    OBJ: 8

39. 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 REF: p. 13| CAAHEP Competency (2015): V.4
    OBJ: 9

40. 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 REF: p. 13| CAAHEP Competency (2015): V.10
    OBJ: 10

41. 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 REF: p. 13| CAAHEP Competency (2015): V.10
    OBJ: 10

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

    ANS: B REF: p. 13| CAAHEP Competency (2015): V.10
    OBJ: 10

43. Which of the following should be included when documenting the administration of medication?
    a. Name of the medication
    b. Route of administration
    c. Dosage administered
    d. Injection site
    e. All of the above

    ANS: E REF: p. 13| CAAHEP Competency (2015): I.12
    OBJ: 8

44. Laboratory tests ordered on a patient at an outside laboratory should be documented in the event which of 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: A REF: p. 14, 16| CAAHEP Competency (2015): I.12
    OBJ: 8

45. Why is it important to document instructions provided to the patient?
    a. To ensure that the patient understands the instructions provided
    b. To protect the provider 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 REF: p. 16| CAAHEP Competency (2015): I.12
    OBJ: 8

46. Flushed skin usually indicates the patient
    a. is experiencing pain.
    b. has an elevated temperature.
    c. has chills.
    d. has a rash.

    ANS: B REF: p. 21| CAAHEP Competency (2015): V.10
    OBJ: 11

47. 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 REF: p. 21| CAAHEP Competency (2015): V.10
    OBJ: 11

48. A decrease in the amount of water in the body is known as
    a. edema.
    b. acidosis.
    c. epistaxis.
    d. dehydration.

    ANS: D REF: p. 21| CAAHEP Competency (2015): V.1
    OBJ: 11

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

    ANS: B REF: p. 21| CAAHEP Competency (2015): V.10
    OBJ: 11

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

    ANS: B REF: p. 21| CAAHEP Competency (2015): V.10
    OBJ: 11