

ADVANCED HEALTH ASSESSMENT CARDIOVASCULAR PRACTICE TEST (SAMPLE) STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE**

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Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	15

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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1. What produces the S1 heart sound?

- A. Closure of the mitral valve
- B. Closure of the aortic valve
- C. Closure of the tricuspid valve
- D. Closure of the pulmonic valve

2. Which statement best describes the management for intermittent claudication?

- A. Tobacco cessation alone is sufficient
- B. Managing HTN, DM, and lipids alone is sufficient
- C. Anti-platelet therapy alone is sufficient
- D. A combination of tobacco cessation, risk factor management, and antiplatelet therapy is recommended

3. PMI stands for which term?

- A. Point of Maximum Impulse
- B. Primary Myocardial Interaction
- C. Posterior Median Interval
- D. Pulmonary Mural Index

4. What technique is used to auscultate aortic regurgitation?

- A. Sit up, lean forward, exhale fully, and auscultate with the diaphragm
- B. Stand up and listen with bell
- C. Lie down and listen with bell
- D. Listen with diaphragm while patient holds breath

5. Physiologic S2 splitting occurs how?

- A. Splits during inspiration and disappears on expiration
- B. Splits during expiration and disappears on inspiration
- C. Fixed splitting
- D. Never splits

- 6. In aortic stenosis, what is true about mean aortic pressure?**
- A. It remains unaffected
 - B. It increases
 - C. It decreases
 - D. It fluctuates widely
- 7. Which diameter defines an abdominal aortic aneurysm?**
- A. Diameter > 3 cm
 - B. Diameter > 5 cm
 - C. Diameter < 2 cm
 - D. Diameter = 3 cm
- 8. A grade 5 murmur is best described as what?**
- A. Loud with palpable thrill, heard with the stethoscope slightly off the chest
 - B. Moderately loud, heard with the stethoscope on the chest
 - C. Quiet, heard only with the stethoscope off the chest
 - D. Very soft, barely heard with the bell in the normal position
- 9. Which condition is commonly associated with physiologic murmurs?**
- A. Anemia
 - B. Aortic stenosis
 - C. Pulmonary hypertension
 - D. Mitral regurgitation
- 10. What is the first step in the cardiovascular assessment?**
- A. Supine with HOB 30 degrees
 - B. Standing
 - C. Prone
 - D. Seated upright

Answers

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1. A
2. D
3. A
4. A
5. A
6. A
7. A
8. A
9. A
10. A

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Explanations

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1. What produces the S1 heart sound?

- A. Closure of the mitral valve**
- B. Closure of the aortic valve
- C. Closure of the tricuspid valve
- D. Closure of the pulmonic valve

S1 arises from the closure of the atrioventricular valves as the ventricles begin to contract at the start of systole. The mitral and tricuspid valves close to prevent backflow into the atria, and the mitral valve's closure is the most audible and typically dominates what clinicians hear as the first heart sound, best at the apex. The timing of this sound aligns with the onset of ventricular systole and the QRS complex on ECG. In contrast, S2 comes from the closure of the semilunar valves (aortic and pulmonic) at the end of systole, so closures of those valves would describe the second heart sound, not the first. The closure of the mitral valve is the best single description for what produces the first heart sound in these options.

2. Which statement best describes the management for intermittent claudication?

- A. Tobacco cessation alone is sufficient
- B. Managing HTN, DM, and lipids alone is sufficient
- C. Anti-platelet therapy alone is sufficient
- D. A combination of tobacco cessation, risk factor management, and antiplatelet therapy is recommended**

Managing intermittent claudication requires a comprehensive approach that reduces overall cardiovascular risk while addressing symptoms. Stopping tobacco use is essential because smoking accelerates atherosclerosis and worsens limb ischemia. Aggressive control of risk factors—blood pressure, diabetes, and lipids—lowers the risk of cardiovascular events and slows disease progression. Antiplatelet therapy further reduces the likelihood of heart attack and stroke in people with peripheral artery disease. When these strategies are combined, you tackle the disease from multiple angles, providing the best overall protection and symptom management. Relying on any single measure—smoking cessation alone, risk-factor management alone, or antiplatelet therapy alone—leaves other important factors unaddressed.

3. PMI stands for which term?

- A. Point of Maximum Impulse**
- B. Primary Myocardial Interaction
- C. Posterior Median Interval
- D. Pulmonary Mural Index

Point of Maximum Impulse is the apical impulse—the strongest beat of the heart felt at the chest wall during systole. It's typically located at the left fifth intercostal space along the midclavicular line and is best felt with the patient in the left lateral decubitus position at the end of expiration. This term is the standard way clinicians describe the impulse produced by the left ventricle as it taps the chest. It's used to assess size and position of the ventricle. A normal, small impulse sits at the apex; if the impulse is displaced laterally or becomes more prominent, it can indicate left ventricular enlargement or other changes in LV geometry. Among the options, only Point of Maximum Impulse is a recognized term in clinical practice. The others aren't standard cardiology terms for this finding.

4. What technique is used to auscultate aortic regurgitation?

- A. Sit up, lean forward, exhale fully, and auscultate with the diaphragm**
- B. Stand up and listen with bell
- C. Lie down and listen with bell
- D. Listen with diaphragm while patient holds breath

Aortic regurgitation produces a high-pitched diastolic murmur that is best heard when the heart is positioned close to the chest wall and the murmur's high-frequency components can be captured. Having the patient sit up and lean forward brings the aortic flow and regurgitant jet toward the chest wall, making the sound more audible at the left sternal border. Listening after full exhalation reduces lung volume, which decreases interference from the lungs and allows the murmur to be heard more clearly. Using the diaphragm is important because it is more sensitive to the high-frequency sounds of AR. Other techniques are less effective for AR: standing and using the bell emphasizes low-frequency sounds, lying down changes the heart's position and can dampen the murmur, and listening with the patient holding their breath doesn't optimize the diastolic flow sound and can alter hemodynamics.

5. Physiologic S2 splitting occurs how?

- A. Splits during inspiration and disappears on expiration**
- B. Splits during expiration and disappears on inspiration
- C. Fixed splitting
- D. Never splits

Normal physiologic S2 splitting arises from the timing difference between the aortic (A2) and pulmonic (P2) valve closures. During inspiration, increased venous return to the right heart lengthens right ventricular systole and delays P2 closure, so A2 and P2 are heard separately as a wider split. During expiration, venous return decreases and the right ventricle finishes earlier, making P2 occur closer to A2 so the sounds fuse and the split disappears. This pattern—split with inspiration that disappears on expiration—is the classic physiologic finding.

6. In aortic stenosis, what is true about mean aortic pressure?

- A. It remains unaffected**
- B. It increases
- C. It decreases
- D. It fluctuates widely

In aortic stenosis, the blockage raises the pressure the left ventricle must generate to push blood through the narrowed valve, creating a large LV systolic pressure to overcome the gradient. The mean pressure in the aorta, however, is governed by the systemic arterial circulation—the balance of cardiac output and systemic vascular resistance over the cardiac cycle. The valve obstruction itself doesn't directly raise or lower the average pressure in the aorta. So, in the absence of heart failure or other decompensation, mean aortic pressure tends to stay essentially the same. If the condition progresses to reduce cardiac output, mean pressure can fall as a secondary effect, but that's not due to the stenosis itself altering the aortic mean pressure directly.

7. Which diameter defines an abdominal aortic aneurysm?

- A. Diameter > 3 cm**
- B. Diameter > 5 cm
- C. Diameter < 2 cm
- D. Diameter = 3 cm

An abdominal aortic aneurysm is defined when the abdominal aorta's diameter is greater than 3 cm. The normal infrarenal aorta is about 2 cm or less, so exceeding 3 cm represents abnormal dilation on imaging. This threshold is used because it reliably distinguishes aneurysmal dilation and correlates with increased risk of rupture as the vessel enlarges. Diameters around 5 cm indicate a higher rupture risk and often prompt surgical planning, but the diagnostic definition remains a diameter greater than 3 cm. A diameter exactly at 3 cm sits at the boundary and is not considered aneurysmal by definition.

8. A grade 5 murmur is best described as what?

- A. Loud with palpable thrill, heard with the stethoscope slightly off the chest**
- B. Moderately loud, heard with the stethoscope on the chest
- C. Quiet, heard only with the stethoscope off the chest
- D. Very soft, barely heard with the bell in the normal position

Grade five murmurs sit at the very loud end of auscultatory grading. They produce a palpable thrill on the chest wall and are heard with the stethoscope partly off the chest. This combination—extremely loud sounds, a palpable thrill, and the need to lift the stethoscope away from the chest to hear clearly—defines this grade. In contrast, lower grades are softer and often require the stethoscope to be placed firmly on the chest, while the very highest grade would be audible with the stethoscope entirely off the chest. So the description of a loud murmur with a palpable thrill and the stethoscope being positioned slightly off the chest correctly characterizes a grade five murmur.

9. Which condition is commonly associated with physiologic murmurs?

- A. Anemia**
- B. Aortic stenosis
- C. Pulmonary hypertension
- D. Mitral regurgitation

Physiologic (innocent) murmurs come from increased blood flow through normal valves, not from valve or chamber pathology. A classic high flow state is anemia, where the heart pumps more blood to meet tissue needs, boosting flow across the heart and generating a soft, systolic flow murmur. It's typically heard at the left upper sternal border and lacks the signs of a pathologic murmur. The other conditions involve structural or vascular disease that changes the valve mechanics or pressures, producing murmurs with characteristic features (for example, a harsh systolic murmur with carotid radiation in aortic stenosis, or a holosystolic blow at the apex in mitral regurgitation). Therefore, anemia is the classic situation associated with physiologic murmurs.

10. What is the first step in the cardiovascular assessment?

A. Supine with HOB 30 degrees

B. Standing

C. Prone

D. Seated upright

Starting with the patient in a semi-upright position (head of bed elevated about 30 degrees) sets up a safe, comfortable baseline for the cardiovascular exam and specifically helps you assess the jugular venous pressure. The 30-degree angle makes the internal jugular veins more visible and allows an accurate estimate of central venous pressure, which is a key part of evaluating right-sided heart function and overall fluid status. This position also provides a stable, accessible view for examining chest wall movement, auscultating heart sounds, and palpating peripheral pulses without forcing the patient into a position that could worsen dyspnea or other symptoms. Standing can make JVP harder to assess and may provoke orthostatic changes with less reliable findings. Prone isn't used for the initial cardiovascular appraisal, and seated upright is used for other measurements or specific maneuvers, but the semi-upright position is the standard starting point for the cardiovascular assessment.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://advhealthassmtcardio.examzify.com>

We wish you the very best on your exam journey. You've got this!

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