Aeromedical Orientation Practice Exam (Sample)

Study Guide

Everything you need from our exam experts!

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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

1. During triage in an aeromedical evacuation, what should accompany any reallocation of resources?

A. During triage in an aeromedical evacuation, what should accompany any reallocation of resources?

B. No documentation needed beyond initial notes.

C. Reallocate resources and document decisions.

D. Document only after mission completion.

2. FDHS stands for which health screen?

A. Flying Duty Health Screen

B. Flying Duty Health Status

C. Flight Duty Health Screen

D. Flying Department Health Screen

3. Which organization is responsible for maintaining aviation medical standards?

A. USACRC (US Army Combat Readiness Center)

B. AAMA (Army Aeromedical Activity)

C. USAARL (US Army Aeromedical Research Laboratory)

D. DAM (Department of Army Aviation Medicine)

4. Which two environmental hazards are identified in aeromedical transport?

A. Humidity and fog.

B. Noise and glare.

C. Turbulence and cold.

D. Radiation and heat.

5. How does cabin altitude relate to the partial pressure of oxygen and the risk of hypoxemia during air transport?

A. Higher cabin altitude increases ambient pressure and raises PO2.

B. Cabin altitude lowers ambient pressure, reducing inspired and arterial PO2, increasing risk of hypoxemia.

C. Cabin altitude has no effect on PO2.

D. Cabin altitude increases humidity, improving oxygenation.

6. How often are Flying Duty Health Screens (FDHS) performed?

A. Quarterly

B. Every two years

C. Monthly

D. Yearly

7. During flight, what ACS management steps are recommended?

A. Rely on symptomatic relief and avoid ECG monitoring.

B. Monitor ECG and vital signs; administer aspirin if not contraindicated; provide oxygen; treat pain; arrange rapid transfer to definitive care.

C. Administer high-dose nitroglycerin only and skip transfer.

D. Wait for definitive care before initiating any in-flight treatments.

8. What is the primary purpose of aeromedical evacuation?

A. To evacuate civilians from disaster areas only.

B. To transport patients by air while delivering medical care in-flight and maximizing patient outcomes during transport.

C. To train medical staff in aviation.

D. To transport cargo quickly.

9. Which statement best describes weight and balance in aeromedical evacuation?

A. It determines airflow in the cabin

B. It has no impact

C. It affects only seating comfort

D. It ensures aircraft stability, controllability, and performance

10. Who takes a Class 2 flight physical?

A. Non-rated crewmembers

B. Rated aviators, flight surgeons, APAs and AMNPs

C. Air traffic controllers

D. UAV operators

Answers

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

Explanations

1. During triage in an aeromedical evacuation, what should accompany any reallocation of resources?

A. During triage in an aeromedical evacuation, what should accompany any reallocation of resources?

B. No documentation needed beyond initial notes.

C. Reallocate resources and document decisions.

D. Document only after mission completion.

During aeromedical evacuation triage, reallocating scarce resources is a time-critical action. The best approach is to accompany any change with concise initial notes that capture what was reallocated, which patients are affected, and why the change was made. This keeps the focus on rapid assessment and safe transport while ensuring there's a trace of decisions for the crew taking over and for the mission record. More detailed or formal documentation isn't expected during the triage phase, though policies may allow fuller records after the mission when feasible. If you were to delay documentation or require extensive forms during triage, it could slow care and create confusion during handoffs.

2. FDHS stands for which health screen?

A. Flying Duty Health Screen

B. Flying Duty Health Status

C. Flight Duty Health Screen

D. Flying Department Health Screen

FDHS stands for Flying Duty Health Screen—the aviation medical evaluation used to certify that an aircrew member is medically fit to perform flying duties. This screening isn't just a status check; it systematically reviews medical history, current medications, and assesses essential fitness areas such as vision, hearing, cardiovascular risk, metabolic health, and mental well-being to ensure safety in flight. It's typically performed on a routine schedule or when health changes occur. The other phrases don't fit because they either describe a general health status, use "Flight" instead of the established "Flying," or refer to a department rather than the duty scope.

3. Which organization is responsible for maintaining aviation medical standards?

A. USACRC (US Army Combat Readiness Center)

B. AAMA (Army Aeromedical Activity)

C. USAARL (US Army Aeromedical Research Laboratory)

D. DAM (Department of Army Aviation Medicine)

The main idea here is that aviation medical standards are set and kept by the Army Aeromedical Activity. This organization oversees the entire flight medicine program, establishing the criteria aircrew must meet to fly, coordinating flight physicals and medical waivers, and ensuring ongoing medical readiness across units. In other words, it serves as the central authority that maintains uniform medical fitness standards for Army aircrew. Other groups have important roles but not the authority to maintain those standards. The US Army Combat Readiness Center focuses on safety and readiness more broadly, not the medical criteria themselves. The Aeromedical Research Laboratory conducts studies to improve aviation medicine, which informs standards but doesn't maintain them. The Department of Army Aviation Medicine provides clinical and support functions, but the policy and standard-setting oversight rests with the Army Aeromedical Activity.

4. Which two environmental hazards are identified in aeromedical transport?

A. Humidity and fog.

B. Noise and glare.

C. Turbulence and cold.

D. Radiation and heat.

The main idea here is how the flight environment creates specific hazards that impact patient safety and care during aeromedical transport. Turbulence is a major environmental hazard because irregular air motion can jostle the aircraft and anything inside it. That movement risks dislodging lines, tubes, and monitoring leads, complicates airway management and IV therapy, and generally makes securing the patient and equipment essential. It also heightens the potential for sudden physiological changes and patient discomfort, so preflight securing, proper restraints, and careful monitoring are key during flight. Cold is the other critical hazard. At altitude the cabin can be very cool, and patients may become hypothermic, especially if they are ill, underdressed, or exposed for extended periods. Hypothermia can worsen coagulopathy, affect medication efficacy, alter heart rate and oxygen delivery, and increase shivering and discomfort. Warm clothing, blankets, warmed IV fluids when appropriate, and active thermal management help mitigate this risk. The other listed factors can cause distress or environmental discomfort, but turbulence and cold are the hazards most consistently emphasized for aeromedical safety and patient care during flight.

5. How does cabin altitude relate to the partial pressure of oxygen and the risk of hypoxemia during air transport?

A. Higher cabin altitude increases ambient pressure and raises PO2.

B. Cabin altitude lowers ambient pressure, reducing inspired and arterial PO2, increasing risk of hypoxemia.

C. Cabin altitude has no effect on PO2.

D. Cabin altitude increases humidity, improving oxygenation.

The tendency being tested is how cabin pressure affects the amount of oxygen your body can use. In flight, the cabin is pressurized to a level equivalent to roughly 6,000–8,000 feet. At that lower ambient pressure, even though oxygen is still about 21% of the air, the partial pressure of oxygen in the air you breathe is reduced. That lowers the inspired PO2, which in turn lowers the alveolar PO2 and arterial PO2, making tissue oxygen delivery less efficient. The result is an increased risk of hypoxemia, especially in people with preexisting cardiopulmonary issues or limited oxygen reserves. Supplemental oxygen helps by increasing the inspired PO2, offsetting the drop from cabin altitude. Humidity doesn't meaningfully improve PO2, so it doesn't reduce hypoxemia risk.

6. How often are Flying Duty Health Screens (FDHS) performed?

A. Quarterly

B. Every two years

C. Monthly

D. Yearly

FDHS are designed as an ongoing check to confirm pilots remain medically fit to fly and to catch evolving health issues before they impact safety. Requiring the screen once a year provides a practical balance between keeping up with any health changes and avoiding unnecessary burden from more frequent testing. Shorter intervals like quarterly or monthly would be excessive for routine issues and add workload, while a gap of two years could miss developing conditions that could compromise flight safety. Therefore, performing FDHS annually best supports continuous, safe operation of flying duties.

7. During flight, what ACS management steps are recommended?

A. Rely on symptomatic relief and avoid ECG monitoring.

B. Monitor ECG and vital signs; administer aspirin if not contraindicated; provide oxygen; treat pain; arrange rapid transfer to definitive care.

C. Administer high-dose nitroglycerin only and skip transfer.

D. Wait for definitive care before initiating any in-flight treatments.

The key idea is to actively manage suspected ACS in flight with ongoing assessment and prompt stabilization to bridge to definitive care. Continuously monitor the ECG and vital signs to detect evolving infarction or dangerous rhythms and to gauge urgency. If there's no contraindication, give aspirin to help prevent further platelet clumping and clot growth, and provide oxygen based on the patient's oxygen saturation and clinical status. Treat pain to reduce sympathetic drive and myocardial oxygen demand, using appropriate medications and using nitroglycerin when not contraindicated and blood pressure allows. Above all, arrange rapid transfer to definitive care and coordinate with medical control or the receiving facility so the patient can get cath lab access or other needed therapies as soon as possible. This approach prioritizes stabilization, early evidence-based interventions, and timely evacuation, which are crucial when you're operating in the constrained in-flight environment.

8. What is the primary purpose of aeromedical evacuation?

A. To evacuate civilians from disaster areas only.

B. To transport patients by air while delivering medical care in-flight and maximizing patient outcomes during transport.

C. To train medical staff in aviation.

D. To transport cargo quickly.

Aeromedical evacuation centers on moving patients by air while providing medical care in flight to keep the patient as stable as possible and improve outcomes during transport. The key is continuous, on-board medical support—vital signs monitoring, airway management, medications, IV therapy, and life-support interventions—so that the patient reaches definitive care quickly with minimal deterioration. This approach combines rapid access to higher-level facilities with ongoing treatment, which is crucial for time-sensitive or critically ill/injured patients. Other options miss this focus: evacuating civilians from disasters is only a part of many missions and not the sole purpose; training medical staff in aviation is a separate activity; and transporting cargo without patient care does not reflect the primary goal of transporting people who need medical treatment during the move.

9. Which statement best describes weight and balance in aeromedical evacuation?

A. It determines airflow in the cabin

B. It has no impact

C. It affects only seating comfort

D. It ensures aircraft stability, controllability, and performance

The key idea is that weight and balance in aeromedical evacuation is about placing all loads so the aircraft's center of gravity stays within certified limits throughout the mission. The CG location relative to the wing and control surfaces determines how stable the aircraft is and how effectively it can be controlled. If the load is too far forward, the airplane becomes nose-heavy, elevator authority is reduced, takeoff and landing distances increase, and stall characteristics can worsen. If the load shifts too far aft, the aircraft can become unstable and harder to control, with a greater risk of abrupt pitch changes or stall. By keeping loads—patient, stretcher, medical equipment, crew, oxygen, fuel—distributed properly, the airplane maintains predictable handling and the required performance: adequate stability, controllability, and performance margins for safe flight. In EMS missions, loads and placements can change as equipment is moved or as fuel burns, so preflight planning and in-flight monitoring ensure the CG stays within limits from start to finish.

10. Who takes a Class 2 flight physical?

A. Non-rated crewmembers

B. Rated aviators, flight surgeons, APAs and AMNPs

C. Air traffic controllers

D. UAV operators

In aeromedical practice, medical exams are aligned with the flying duties of the person. Class 2 is the level of medical evaluation for aircrew who actually fly or closely support flight operations. Rated aviators must have ongoing medical certification to exercise flight privileges, and flight surgeons are the physicians who manage aircrew medical standards; both fall under this Class 2 category. APAs and AMNPs are clinicians who work directly in aviation medicine and support flight crews, so they also operate under the same certification level. Non-rated crewmembers, air traffic controllers, and UAV operators aren't considered aircrew in the same sense or fall under different medical categories, so they don't routinely take a Class 2 flight physical.

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://aeromedorientation.examzify.com

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