

ARMY DEPLOYED MEDICAL PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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. Name two malaria prophylaxis options commonly used in deployed settings.**
 - A. Doxycycline and atovaquone-proguanil.
 - B. Mefloquine and chloroquine.
 - C. Primaquine and doxycycline.
 - D. Artemisinin-based combination therapy and quinine.
- 2. Which of the following are signs of a suspected extremity fracture?**
 - A. Numbness without swelling
 - B. Bruising only
 - C. Swelling and crepitus under the skin
 - D. Redness
- 3. A penetrating chest wound should raise suspicion for which complication?**
 - A. Tension pneumothorax
 - B. Open pneumothorax
 - C. Hemothorax
 - D. Cardiac tamponade
- 4. Which statement best describes a sign of an extremity fracture in the field?**
 - A. Fever and fatigue
 - B. Pain upon movement only
 - C. Bruising
 - D. Swelling and crepitus under the skin
- 5. What is the immediate action if a casualty goes into cardiac arrest in the field?**
 - A. Check for responsiveness and signs of life
 - B. Call for help and wait for EMS
 - C. Administer high-flow oxygen only
 - D. Initiate CPR immediately and apply an AED if available; minimize interruptions and evacuate as needed.

- 6. What is the principle of resuscitation in hemorrhagic shock encountered in the field?**
- A. Aggressive fluid resuscitation to normal BP
 - B. Delayed hemorrhage control until stable
 - C. Early use of vasopressors
 - D. Control hemorrhage first, provide warmed IV fluids as needed, and avoid over-resuscitation to prevent exacerbating bleeding
- 7. Which statement is NOT a typical evacuation criterion from a field medical unit?**
- A. Deterioration without improvement
 - B. Stable vitals for 24 hours
 - C. Uncontrolled hemorrhage
 - D. Need for surgical intervention
- 8. What is the recommended TXA dose and time window for battlefield trauma?**
- A. 2 grams IV/IO within 6 hours.
 - B. 1 gram IV/IO within 24 hours.
 - C. 0.5 gram IV/IO immediately.
 - D. 1 gram IV/IO as soon as possible, ideally within 3 hours of injury.
- 9. When is intraosseous access preferred over IV in a deployed setting?**
- A. When IV access is difficult or time-consuming due to shock or poor peripheral veins; IO is rapid and reliable in austere conditions
 - B. When skilled personnel available
 - C. Only after IV success
 - D. In all patients regardless
- 10. Which sequence is correct for controlling life-threatening extremity hemorrhage in the field?**
- A. Begin with applying a tourniquet proximal to the wound, without direct pressure.
 - B. Apply direct pressure first; if bleeding persists, apply a tourniquet proximal to the wound, record the time, and reassess distal status.
 - C. Apply direct pressure, then immediately leave the wound to evac without further intervention.
 - D. Apply direct pressure first and ignore the possibility of a tourniquet.

Answers

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

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Explanations

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1. Name two malaria prophylaxis options commonly used in deployed settings.

- A. Doxycycline and atovaquone-proguanil.**
- B. Mefloquine and chloroquine.
- C. Primaquine and doxycycline.
- D. Artemisinin-based combination therapy and quinine.

In deployed settings, malaria prophylaxis focuses on regimens that are effective against resistant parasites, safe and tolerable in the field, and easy to take consistently. Doxycycline and atovaquone-proguanil fit this need well. Doxycycline is taken once daily and started a couple days before exposure, then continued daily during the deployment and for several weeks after returning. It provides good protection against blood-stage parasites, including chloroquine-resistant strains, and is affordable and widely available. Its downsides are photosensitivity and possible GI upset, and it isn't used in pregnancy or in young children. Atovaquone-proguanil is also a daily regimen, started just before travel and continued for a week after leaving the risk area. It has a favorable tolerability profile and is effective against resistant strains, with the practical advantage of a shorter post-travel tail compared to doxycycline. However, it's more expensive and not suitable for certain populations (for example, it's avoided in pregnancy in some guidelines). Other options exist but are less commonly used in typical deployed scenarios for routine prevention: mefloquine is a weekly option but can have neuropsychiatric side effects that limit its use in some personnel; chloroquine is unreliable in many regions due to resistance; primaquine is reserved for specific situations and requires G6PD testing because of risk of hemolysis; ACTs and quinine are treatments, not prophylaxis. So, the two commonly used malaria prophylaxis options in deployed settings are doxycycline and atovaquone-proguanil because they provide reliable protection with practical dosing and manageable safety profiles in field conditions.

2. Which of the following are signs of a suspected extremity fracture?

- A. Numbness without swelling
- B. Bruising only
- C. Swelling and crepitus under the skin**
- D. Redness

Swelling and a crackling sensation under the skin point to a break in the bone with tissue injury, which is a strong indicator of a fracture. Swelling results from bleeding and inflammation around the injured bone, while crepitus occurs when broken bone fragments move or air is present in the tissues, producing that unmistakable crackling feel or sound. Together, they are reliable signs that the limb could be fractured. Numbness without swelling can happen with nerve involvement but isn't a definitive sign of fracture on its own. Bruising by itself can occur with many soft-tissue injuries and doesn't prove a fracture. Redness alone is not specific to fractures and can come from irritation or other causes. If you suspect a fracture, immobilize the limb and seek prompt medical care, ensuring distal sensation and circulation are checked before and after immobilization.

3. A penetrating chest wound should raise suspicion for which complication?

A. Tension pneumothorax

B. Open pneumothorax

C. Hemothorax

D. Cardiac tamponade

Penetrating chest wounds can introduce air into the pleural space and, if air continues to be pulled in but cannot escape, a one-way valve effect develops. This causes the pneumothorax to become under pressure, collapsing the lung on the injured side and shifting the mediastinum toward the opposite side. The result is impaired venous return to the heart and rapidly increasing instability, which is a life-threatening situation requiring immediate intervention. In the field, a patient may become increasingly short of breath, develop hypotension, distended neck veins, and possibly tracheal deviation, with a hyperresonant and diminished or absent breath sound on the affected side. Because this progression to tension pneumothorax can crash blood pressure quickly, it's the condition you must suspect and treat first with prompt needle decompression followed by chest tube placement. Open pneumothorax can occur with chest wall breaches, but it describes air entering and leaving through the wound rather than building pressure that compresses the heart and opposite lung. Hemothorax involves blood in the chest cavity and causes chest dullness to percussion and reduced breath sounds, but it doesn't inherently produce the rapid hemodynamic collapse caused by tension pneumothorax. Cardiac tamponade from penetrating injury is also dangerous, but tension pneumothorax is the form of pressure-related compromise most immediately linked to a penetrating chest wound in the urgent, prehospital setting.

4. Which statement best describes a sign of an extremity fracture in the field?

A. Fever and fatigue

B. Pain upon movement only

C. Bruising

D. Swelling and crepitus under the skin

In the field, a reliable indicator of an extremity fracture is swelling accompanied by crepitus under the skin. Swelling signals bleeding into soft tissues from a damaged bone, while crepitus is the crackling sensation or sound produced when fractured bone ends rub against each other. This combination is highly specific for a fracture, making it the best sign in austere conditions. Fever and fatigue aren't direct signs of a fracture; they point to systemic illness or infection. Pain with movement is common in many injuries and isn't as specific, and bruising can occur with sprains or contusions as well as fractures, so it's less definitive on its own.

5. What is the immediate action if a casualty goes into cardiac arrest in the field?

- A. Check for responsiveness and signs of life
- B. Call for help and wait for EMS
- C. Administer high-flow oxygen only
- D. Initiate CPR immediately and apply an AED if available; minimize interruptions and evacuate as needed.**

In field cardiac arrest, the priority is to restore circulation as quickly as possible through immediate high-quality CPR and defibrillation if an AED is available. Chest compressions keep blood flowing to the brain and heart, buying time while a shockable rhythm is identified and treated with defibrillation. Using the AED as soon as it's ready increases the chance of a successful return of spontaneous circulation. Minimizing interruptions to chest compressions preserves perfusion and improves outcomes, so resume CPR immediately after any shock or device analysis. Evacuate for advanced care as needed, but don't delay life-saving actions to move the casualty. Oxygen alone cannot restart the heart, and waiting to call for help or to administer oxygen would miss the critical early window for defibrillation and perfusion.

6. What is the principle of resuscitation in hemorrhagic shock encountered in the field?

- A. Aggressive fluid resuscitation to normal BP
- B. Delayed hemorrhage control until stable
- C. Early use of vasopressors
- D. Control hemorrhage first, provide warmed IV fluids as needed, and avoid over-resuscitation to prevent exacerbating bleeding**

The idea being tested is damage-control resuscitation: the priority is to stop the bleeding first and protect the patient from the chain reaction that can come with ongoing hemorrhage. In the field, that means directly controlling the hemorrhage as soon as possible, while providing warmed IV fluids only as needed to maintain perfusion. Importantly, avoid over-resuscitation that can raise blood pressure before the source is controlled, because higher pressure can dislodge clots and worsen bleeding. Keeping the patient warm helps prevent hypothermia, which worsens coagulopathy, and if available, using blood products rather than large volumes of crystalloids supports clotting. Vasopressors aren't the main tool here because they don't stop bleeding and can compromise tissue perfusion without addressing the bleed.

7. Which statement is NOT a typical evacuation criterion from a field medical unit?

- A. Deterioration without improvement
- B. Stable vitals for 24 hours**
- C. Uncontrolled hemorrhage
- D. Need for surgical intervention

The point of field evacuation criteria is to move patients who truly need higher-level care or rapid escalation. If a patient shows signs of deterioration or if there is life-threatening trouble that cannot be managed at the field unit—such as uncontrolled bleeding or a condition requiring surgical intervention—that clearly warrants evacuation. In contrast, a patient who remains hemodynamically stable and has had stable vitals for a full 24 hours is not something that automatically triggers transfer; stability suggests they can be cared for at the current facility and monitored locally. Of course, decisions can vary with resource limits or evolving needs, but as a typical criterion for evacuation, maintaining stable vitals for 24 hours is not a common trigger.

8. What is the recommended TXA dose and time window for battlefield trauma?

- A. 2 grams IV/IO within 6 hours.
- B. 1 gram IV/IO within 24 hours.
- C. 0.5 gram IV/IO immediately.

D. 1 gram IV/IO as soon as possible, ideally within 3 hours of injury.

Early use of tranexamic acid in battlefield trauma aims to prevent excessive breakdown of clots after injury. It does this by blocking plasminogen's transformation into plasmin, helping to stabilize clots and reduce ongoing bleeding. The most important factor is timing: the survival benefit is strongest when TXA is given as soon as possible and within about 3 hours of injury. The standard dosing approach is a 1 gram IV or IO bolus given promptly, with a second 1 gram dose over the next 8 hours if bleeding persists. In austere, combat settings, delivering 1 gram promptly and aiming for within 3 hours captures both the mechanism and the critical window for benefit. The other options involve dosing or timing that either is not the standard regimen or misses the optimal window for effectiveness.

9. When is intraosseous access preferred over IV in a deployed setting?

- A. When IV access is difficult or time-consuming due to shock or poor peripheral veins; IO is rapid and reliable in austere conditions
- B. When skilled personnel available

C. Only after IV success

D. In all patients regardless

In a deployed, austere setting the main reason to choose intraosseous access is when IV access is difficult or time-consuming due to shock or poor peripheral veins. In severe blood loss or shock, vessels constrict and veins can collapse, making repeated IV attempts slow and often futile. The intraosseous route taps into the bone marrow's venous sinusoids, giving rapid, reliable access to the central circulation without depending on peripheral veins. This allows fluids and medications to be delivered quickly, which is crucial when every second matters in resuscitation. This approach is not about having more skilled personnel or waiting until an IV attempt has succeeded. It is about avoiding delays by opting for a fast, dependable route as soon as IV access is unlikely or time-consuming. It's not used universally for all patients; there are situations where IO isn't appropriate (injury to the bone, infection at the insertion site, or specific contraindications), but in austere, time-critical scenarios, it's the preferred option whenever IV access would be slow or unreliable.

10. Which sequence is correct for controlling life-threatening extremity hemorrhage in the field?

- A. Begin with applying a tourniquet proximal to the wound, without direct pressure.
- B. Apply direct pressure first; if bleeding persists, apply a tourniquet proximal to the wound, record the time, and reassess distal status.**
- C. Apply direct pressure, then immediately leave the wound to evac without further intervention.
- D. Apply direct pressure first and ignore the possibility of a tourniquet.

In controlling life-threatening extremity hemorrhage, the immediate step is to apply direct pressure to the wound to clamp down bleeding. This simple, first-line technique works quickly for many injuries and helps stabilize the patient. If bleeding remains uncontrolled after firm direct pressure, the next step is to apply a tourniquet proximal to the wound to stop arterial inflow and halt the bleed. Recording the time the tourniquet is applied is essential, because it communicates how long the limb has been without perfusion and guides ongoing care. After the tourniquet is in place, reassess distal status—check for distal circulation, color, warmth, and overall limb perfusion—to ensure that the intervention is effective and to detect any signs of evolving complications. The other sequences fall short because they skip or delay the necessary escalation to a tourniquet when direct pressure fails, or they omit the vital step of reassessing distal perfusion after stopping the bleed.

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:

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

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