

Emergency Department Course 1 - Past Histories & ED Flow Practice Test (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

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- 1. What role does a patient's social history play in their emergency care?**
 - A. It determines the patient's insurance coverage**
 - B. It helps address potential influences on health and treatment**
 - C. It establishes the patient's primary care physician**
 - D. It is used solely for demographic analysis**

- 2. What should be documented as the chief concern of a patient?**
 - A. PMHx**
 - B. SHx**
 - C. CC**
 - D. PHx**

- 3. Are scribes allowed to give or pass on verbal orders?**
 - A. Yes, they are allowed**
 - B. No, that is prohibited**
 - C. Only with the physician present**
 - D. Yes, if they have training**

- 4. Which term refers to heart failure in medical terminology?**
 - A. Cardiac collapse**
 - B. Congestive heart failure**
 - C. Chronological heart dysfunction**
 - D. Cardiovascular insufficiency**

- 5. What does EHR stand for in a medical context?**
 - A. Emergency Health Record**
 - B. Electronic Health Record**
 - C. Extended Health Report**
 - D. Essential Health Record**

- 6. At what stage does the Chief complaint and vital signs get recorded?**
- A. History**
 - B. Triage**
 - C. Physical Exam**
 - D. MDM**
- 7. What does the acronym "LOC" stand for in an emergency medical context?**
- A. Level of care**
 - B. Loss of consciousness**
 - C. Level of consciousness**
 - D. Latency of condition**
- 8. What critical factor should be assessed regarding a patient's substance use history?**
- A. Duration of hospitalization**
 - B. Types of substances used and frequency**
 - C. Family history of addiction**
 - D. Criminal background**
- 9. What medical condition is typically referred to as a stroke?**
- A. Cerebral thrombosis**
 - B. Cerebrovascular accident**
 - C. Transient ischemic attack**
 - D. Hemorrhagic attack**
- 10. What role does family history play in patient evaluations in the ED?**
- A. It provides insight into possible genetic conditions**
 - B. It is irrelevant and rarely discussed**
 - C. It only matters for elderly patients**
 - D. It typically increases patient wait times**

Answers

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

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Explanations

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1. What role does a patient's social history play in their emergency care?
 - A. It determines the patient's insurance coverage
 - B. It helps address potential influences on health and treatment**
 - C. It establishes the patient's primary care physician
 - D. It is used solely for demographic analysis

The role of a patient's social history in emergency care is crucial, as it provides insights into potential influences on the patient's health and treatment options. Social history encompasses various factors, such as living conditions, employment status, substance use, and social support systems. Understanding these aspects can help healthcare providers identify barriers to care, assess risks for specific health conditions, and tailor interventions to best meet the patient's needs. For instance, knowing if a patient lives in an unsafe environment can lead to considerations for safety planning. Recognizing substance use can inform treatment decisions, especially if the patient may require specific interventions or support. Additionally, social history can reveal emotional or psychological stressors that may impact the patient's health, aiding in the comprehensive evaluation and management of the patient's condition in the emergency department. The other choices do not fully encompass the breadth of potential benefits that a thorough understanding of social history brings to emergency care. While understanding insurance coverage is practical for administrative purposes, it does not directly impact clinical decision-making as social factors do. Establishing a primary care physician might be important for continuity of care but is secondary to the immediate concerns addressed during an emergency. Lastly, using social history solely for demographic analysis limits its potential to inform and improve patient care.

2. What should be documented as the chief concern of a patient?
 - A. PMHx
 - B. SHx
 - C. CC**
 - D. PHx

The chief concern of a patient is documented as the Chief Complaint (CC). This is the primary issue or symptom that the patient presents with while seeking medical care. Accurately recording the chief complaint is crucial as it sets the focus for the entire clinical evaluation and guides the healthcare provider in determining the appropriate course of action. The chief complaint is typically stated in the patient's own words and reflects their immediate health concern, which can help direct the clinical assessment and any necessary interventions. It is foundational to formulating a diagnosis and creating a treatment plan tailored to the patient's needs. Other options like PMHx (Past Medical History), SHx (Social History), and PHx (Past History) provide important contextual information about the patient's background and previous health issues, but they do not represent the immediate concern that brought the patient to the emergency department. Each of these histories contributes to the overall assessment but does not substitute the need for a clear and documented chief complaint.

3. Are scribes allowed to give or pass on verbal orders?

- A. Yes, they are allowed
- B. No, that is prohibited**
- C. Only with the physician present
- D. Yes, if they have training

The correct understanding is that scribes are not allowed to give or pass on verbal orders. This prohibition is in place to maintain the integrity and safety of patient care. Verbal orders must come directly from a licensed practitioner, typically a physician, to ensure that there is clear accountability and authority in the communication of clinical directives. Scribes are trained to document information and assist with various administrative tasks in the emergency department, but they do not have the medical training or authority to make decisions regarding patient treatment. Allowing scribes to issue verbal orders could lead to miscommunication, potential errors in patient care, and liabilities for both the healthcare providers and the institution. Ensuring that only qualified medical personnel communicate orders helps to uphold standards of care and protects patient safety.

4. Which term refers to heart failure in medical terminology?

- A. Cardiac collapse
- B. Congestive heart failure**
- C. Chronological heart dysfunction
- D. Cardiovascular insufficiency

The term "congestive heart failure" is the correct choice as it specifically refers to a condition where the heart is unable to pump blood effectively, leading to a buildup of fluid in the lungs, liver, and other tissues. This condition encompasses both the mechanical failure of the heart and the resultant congestion that occurs due to the inefficiency of the heart in managing blood flow. Congestive heart failure is a well-defined medical term recognized and used widely in clinical settings to describe chronic conditions characterized by the heart's impaired ability to perform its function, ultimately affecting the patient's circulation and fluid balance. Its prevalence in medical literature and ongoing usage in clinical practice underscores its importance as a clear and precise label for this complex syndrome, differentiating it from other cardiovascular conditions. Other options, while they may describe heart-related issues, do not accurately encompass the defined medical condition represented by congestive heart failure. For instance, "cardiac collapse" implies a sudden failure that is not synonymous with the chronic nature of heart failure. "Chronological heart dysfunction" is not a standard medical term and lacks specificity. "Cardiovascular insufficiency" might be interpretable but does not capture the congestion aspect crucial to diagnosing and managing heart failure. These distinctions illustrate the utility

5. What does EHR stand for in a medical context?

- A. Emergency Health Record
- B. Electronic Health Record**
- C. Extended Health Report
- D. Essential Health Record

In a medical context, EHR stands for Electronic Health Record. This term refers to a digitized version of a patient's paper chart and encompasses a comprehensive collection of medical history, treatment plans, medications, immunization dates, allergies, radiology images, and laboratory test results. EHRs are designed to be accessed by multiple healthcare providers and facilitate the sharing of information across different healthcare systems, ultimately leading to improved patient care and outcomes. The electronic format allows for quicker updates, better data analysis, and streamlined communication between patients and providers. This digital transformation is essential for modern healthcare delivery, as it enhances efficiency, reduces errors, and supports high-quality medical care.

6. At what stage does the Chief complaint and vital signs get recorded?

- A. History
- B. Triage**
- C. Physical Exam
- D. MDM

The recording of the Chief Complaint and vital signs occurs during the triage stage of the emergency department workflow. Triage is a critical initial step in the patient care process where patients are evaluated and prioritized based on the severity of their condition. In this phase, the triage nurse collects essential information, including the patient's primary reason for seeking care, which is noted as the Chief Complaint. Additionally, vital signs—such as heart rate, blood pressure, temperature, and respiratory rate—are taken to assess the patient's immediate health status. This information is crucial as it helps determine the urgency of the patient's needs and informs the subsequent steps in their care, ensuring that the most critical cases receive timely attention.

7. What does the acronym "LOC" stand for in an emergency medical context?

- A. Level of care**
- B. Loss of consciousness**
- C. Level of consciousness**
- D. Latency of condition**

In an emergency medical context, the acronym "LOC" stands for "Level of consciousness." This term is critical in assessing a patient's neurological status and determining the degree of alertness or responsiveness they exhibit during an evaluation. The level of consciousness can provide essential information about the patient's condition, guiding emergency medical personnel in making rapid decisions regarding treatment and intervention. Understanding the level of consciousness is vital, especially in situations where a patient may have suffered trauma, a stroke, or other medical emergencies that can affect brain function. Medical professionals often use standardized scales, such as the Glasgow Coma Scale, to quantify a patient's level of consciousness, allowing for effective communication among caregivers and facilitating appropriate care strategies.

8. What critical factor should be assessed regarding a patient's substance use history?

- A. Duration of hospitalization**
- B. Types of substances used and frequency**
- C. Family history of addiction**
- D. Criminal background**

Assessing the types of substances used and their frequency is crucial in understanding a patient's substance use history. This information provides essential insight into the patient's pattern of use, potential for dependence or addiction, and risk factors for substance-related complications. Different substances can have varying effects on health and can require distinct approaches to treatment and management. For instance, knowing whether a patient uses alcohol, opioids, stimulants, or multiple substances can inform the emergency team about the potential physical effects, withdrawal symptoms, and the urgency of interventions needed. The frequency of use helps clinicians gauge the severity of the patient's condition and tailor their approach to detoxification or treatment programs accordingly. Understanding these factors can significantly impact the care provided in the emergency department and influence long-term management strategies.

9. What medical condition is typically referred to as a stroke?

- A. Cerebral thrombosis**
- B. Cerebrovascular accident**
- C. Transient ischemic attack**
- D. Hemorrhagic attack**

A stroke is most commonly referred to as a cerebrovascular accident (CVA). This term encompasses various types of strokes, including those caused by the interruption of blood flow to the brain, which results in a lack of oxygen and can cause brain cell death. The classification into this broader category allows healthcare professionals to identify and address a wide range of conditions affecting the cerebral blood vessels.

Cerebrovascular accidents can be divided into two main types: ischemic strokes, where blood flow is blocked (which could include situations like cerebral thrombosis), and hemorrhagic strokes, where there is bleeding in the brain. The term cerebrovascular accident is used in clinical practice to emphasize the event's sudden nature and the immediate impact on brain function, which distinguishes it from transient ischemic attacks, commonly known as TIAs. TIAs, while significant, are temporary interruptions of blood flow that do not cause permanent damage, making them a different entity. In summary, cerebrovascular accident is the encompassing term that describes strokes, thereby identifying both immediate emergency interventions and long-term management strategies that may be necessary for recovery and rehabilitation after such an event.

10. What role does family history play in patient evaluations in the ED?

- A. It provides insight into possible genetic conditions**
- B. It is irrelevant and rarely discussed**
- C. It only matters for elderly patients**
- D. It typically increases patient wait times**

Family history plays a crucial role in patient evaluations in the Emergency Department because it provides valuable insight into possible genetic conditions that may affect the patient. Understanding the health issues that relatives have experienced can help clinicians identify hereditary diseases or predispositions to certain illnesses. This information can guide the diagnostic process, influence management strategies, and assist in identifying risk factors for conditions prevalent in the patient's family. For instance, knowing about a family history of cardiovascular disease, certain cancers, or metabolic disorders can lead clinicians to consider these conditions when assessing the patient's symptoms. This context is essential for making informed clinical decisions and offering appropriate care tailored to the individual patient's background.

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://edpasthistoriesandflow.examzify.com>

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

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