Female Gynecologic History and Physical (H&P) Practice Test (Sample)

Study Guide

Everything you need from our exam experts!

Sample study guide. For the full version with hundreds of questions, visit:
https://femalegynhistoryphysical.examzify.com

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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.

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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!

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Questions

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1. **When documenting cervical os status, what information should be included?**
   - A. Opening status and clinical context, such as pregnancy or delivery status.
   - B. Only a numerical value.
   - C. Document os status only if symptoms are present.
   - D. Os status should be omitted from the record.

2. **Which features in the history suggest abnormal uterine bleeding (AUB)?**
   - A. Irregular timing only.
   - B. Heavy menses with clots.
   - C. Intermenstrual bleeding.
   - D. AUB features include irregular timing, duration, or amount; heavy menses with clots; intermenstrual bleeding; postcoital bleeding; and anemia symptoms.

3. **Gardasil is contraindicated in patients with which allergy?**
   - A. Yeast allergy
   - B. Milk allergy
   - C. Egg allergy
   - D. Latex allergy

4. **Which components are essential to document in the initial female gynecologic history and physical (H&P)?**
   - A. History sections include menstrual history, obstetric history, sexual history, contraception history, gynecologic symptoms, urinary symptoms, breast history, medical/surgical history, medications, allergies, family history, and social history; the physical includes general exam, breast exam, external genitalia, speculum exam, and bimanual pelvic exam when indicated.
   - B. History includes only menstrual and obstetric history; physical exam focuses on breast and external genitalia.
   - C. History is optional; physical exam is limited to abdominal palpation.
   - D. History and physical are completed only at the patient's request.

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5. **What is rectocele?**
    - A. Prolapse of the uterus into the vagina
    - B. Herniation of the bladder into the vagina
    - C. Herniation of the rectum into the vagina
    - D. Herniation of the sigmoid colon into the vagina

6. **What is the current evidence regarding breast self-examination effectiveness?**
    - A. Strongly supports effectiveness
    - B. There is little evidence either way
    - C. Proven to reduce mortality
    - D. Not recommended

7. **How often should women at average risk undergo a screening mammogram?**
    - A. Every 1-2 years
    - B. Annually
    - C. Every 3-5 years
    - D. Every 6-12 months

8. **Which of the following is a possible etiology of milky nipple discharge?**
    - A. Bacterial pneumonia
    - B. Iron deficiency anemia
    - C. Pregnancy
    - D. Osteoporosis

9. **Clinical breast examination is offered to women aged 25-39 years every 1-3 years, and starting at age 40 it may be offered annually.**
    - A. 15-24 years
    - B. 25-39 years every 1-3 years; 40+ annually
    - C. 40-60 every 2 years
    - D. Not offered

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10. Which of the following is identified as a risk-reduction strategy for breast cancer?

- **A. Undergo routine mammography starting at age 40**
- **B. Plan for first birth before age 30**
- **C. Limit calcium intake**
- **D. Use tanning beds regularly**

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Answers

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

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Explanations

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1. **When documenting cervical os status, what information should be included?**

    A. <u>**Opening status and clinical context, such as pregnancy or delivery status.**</u>

    B. **Only a numerical value.**

    C. **Document os status only if symptoms are present.**

    D. **Os status should be omitted from the record.**

Documenting cervical os status requires both how open the os is and the clinical context in which this finding is made. The opening, or dilation, tells you how far the cervix has progressed (for example, how many centimeters it is dilated). But the meaning of that dilation depends on the patient's current obstetric situation. Is the patient pregnant and in active labor, or has labor already progressed to a different stage, or has delivery occurred recently? Including the pregnancy or delivery status with the opening measurement provides the necessary context to interpret how far along the labor is and what management steps are appropriate. Merely recording a numeric value without this context can be misleading, and documenting os status only when symptoms are present or omitting it altogether misses essential information used for ongoing obstetric care.

2. **Which features in the history suggest abnormal uterine bleeding (AUB)?**

    A. **Irregular timing only.**

    B. **Heavy menses with clots.**

    C. **Intermenstrual bleeding.**

    D. <u>**AUB features include irregular timing, duration, or amount; heavy menses with clots; intermenstrual bleeding; postcoital bleeding; and anemia symptoms.**</u>

The important concept is that abnormal uterine bleeding is defined by any pattern of vaginal bleeding that deviates from what’s expected in a regular cycle, including the timing, the amount, or the duration of bleeding, and it can also involve bleeding between cycles or after intercourse, with possible signs of anemia from blood loss. The best answer reflects the full range of history clues physicians use to recognize AUB: irregular timing, or variation in how long the menses lasts and how heavy it is; heavy menses with clots; bleeding between cycles (intermenstrual bleeding); bleeding after intercourse; and symptoms that suggest anemia from chronic blood loss. Each element highlights a different way the uterus or its surroundings can behave abnormally, and together they capture the broad spectrum of presentations. Focusing on only one facet—timing alone, or heavy flow alone, or intermenstrual bleeding alone—misses the larger pattern clinicians rely on to identify AUB.

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3. Gardasil is contraindicated in patients with which allergy?

A. Yeast allergy

B. Milk allergy

C. Egg allergy

D. Latex allergy

Gardasil is produced using yeast cells (Saccharomyces cerevisiae) and contains yeast-derived protein. Because of this, a person with a yeast allergy can have a hypersensitivity reaction to the vaccine. The other listed allergies—milk, egg, and latex—are not related to the vaccine's production or components, so they do not represent true contraindications. Egg allergy is a concern for some vaccines produced in eggs, but Gardasil is yeast-based, not egg-based. Latex allergy would only matter if latex-containing packaging were the issue, not due to the vaccine's active components. Therefore, yeast allergy is the contraindication.

4. Which components are essential to document in the initial female gynecologic history and physical (H&P)?

A. History sections include menstrual history, obstetric history, sexual history, contraception history, gynecologic symptoms, urinary symptoms, breast history, medical/surgical history, medications, allergies, family history, and social history; the physical includes general exam, breast exam, external genitalia, speculum exam, and bimanual pelvic exam when indicated.

B. History includes only menstrual and obstetric history; physical exam focuses on breast and external genitalia.

C. History is optional; physical exam is limited to abdominal palpation.

D. History and physical are completed only at the patient's request.

A comprehensive history and a thorough physical exam are essential for the initial female gynecologic H&P. The history should cover menstrual history, obstetric history, sexual history, contraception history, gynecologic symptoms, urinary symptoms, breast history, medical/surgical history, medications, allergies, family history, and social history. This breadth ensures you understand fertility status, pregnancy potential, STI risk, contraception needs, symptom patterns, and family cancer risk, and it guides preventive care and screening plans. The physical exam should include a general exam, breast examination, external genitalia inspection, a speculum exam to visualize the cervix and vaginal walls, and a bimanual pelvic exam when indicated by age, symptoms, or risk factors. Together, these elements establish a solid baseline, help detect problems early, and drive appropriate management. The other options fall short because they truncate important domains—omitting substantial parts of history or parts of the exam—or suggest the history is optional or only performed at the patient's request, which is not appropriate for a standard initial visit or for patient safety and quality care.

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5. What is rectocele?

A. Prolapse of the uterus into the vagina

B. Herniation of the bladder into the vagina

C. Herniation of the rectum into the vagina

D. Herniation of the sigmoid colon into the vagina

Rectocele is a protrusion of the rectum into the vaginal canal due to weakening of the posterior vaginal wall and the rectovaginal septum. This posterior compartment prolapse happens when pelvic floor supports are injured or stretched, often from vaginal childbirth, aging, obesity, or chronic straining with constipation. Clinically, you'll typically notice a bulge on the back wall of the vagina, a sense of fullness or pressure, and sometimes difficulty with bowel movements or the need to manually assist defecation by bearing down into the vagina. On exam, a posterior vaginal wall bulge is seen and the rectum can be felt protruding into the vaginal canal. The other descriptions refer to different pelvic organ prolapses: a uterus protruding into the vagina is a uterine prolapse; the bladder protruding into the vagina is a cystocele; herniation of the sigmoid colon (and sometimes small bowel) into the vagina is an enterocele. Rectocele specifically means the rectum herniating through the posterior vaginal wall.

6. What is the current evidence regarding breast self-examination effectiveness?

A. Strongly supports effectiveness

B. There is little evidence either way

C. Proven to reduce mortality

D. Not recommended

The test is about how solid the evidence is for breast self-examination actually improving outcomes. Large, well-designed studies and reviews have not shown a clear mortality benefit from routine self-exams, and in some cases they increase false positives, leading to unnecessary anxiety and biopsies without proving a survival advantage. Because of this, the evidence doesn't support routine self-exams as a proven screening tool. Current guidance emphasizes breast awareness—being familiar with how the breast normally feels and promptly reporting any new lump, change, or nipple discharge—while relying on regular screening mammography and clinical breast exams for mortality reduction. So, there is little evidence either way regarding effectiveness.

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7. How often should women at average risk undergo a screening mammogram?

A. Every 1-2 years

B. Annually

C. Every 3-5 years

D. Every 6-12 months

The key idea here is choosing a screening schedule that catches cancers early while minimizing harms from testing. For women at average risk, the evidence supports a biennial to semi-annual approach—specifically every 1-2 years—as the best balance. Annual screening increases cumulative radiation exposure and raises the chances of false positives, unnecessary biopsies, and anxiety, without a proportional increase in mortality benefit. Waiting 3-5 years could allow cancers to grow undetected between screens, reducing the chance of early treatment. Therefore, screening every 1-2 years offers meaningful early detection with fewer downsides for most women at average risk.

8. Which of the following is a possible etiology of milky nipple discharge?

A. Bacterial pneumonia

B. Iron deficiency anemia

C. Pregnancy

D. Osteoporosis

Milky nipple discharge occurs when the breast ducts secrete milk-like fluid outside of normal lactation, usually from elevated prolactin during milk production. Pregnancy is a normal state that dramatically raises lactogenic hormones, especially prolactin, to prepare the breasts for milk. As pregnancy progresses, the breasts become capable of producing milk, and colostrum or milky discharge can appear even before birth. That physiological rise in prolactin explains milky discharge in pregnancy. The other choices don't relate to lactation: pneumonia is a lung infection, iron deficiency anemia doesn't drive milk production, and osteoporosis affects bone health, not the milk-producing pathway.

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9. Clinical breast examination is offered to women aged 25-39 years every 1-3 years, and starting at age 40 it may be offered annually.

A. 15-24 years

B. 25-39 years every 1-3 years; 40+ annually

C. 40-60 every 2 years

D. Not offered

The idea being tested is how breast examination is scheduled by age to balance early detection with avoiding unnecessary testing. The recommended approach here is to offer clinical breast examination to women who are 25–39 years old about every 1–3 years, and to consider offering it annually once women reach age 40. This reflects the pattern that younger women have a lower short-term risk of breast cancer, so less frequent screening is reasonable, while the risk rises with age, making more frequent examination appropriate as women get older or when other risk factors are present. Why this fits best: starting at 25 targets early-adult women during routine care, but with intervals that aren’t overly frequent. As women approach and exceed 40, the guidance emphasizes more regular assessment, up to an annual check, to increase opportunities to detect abnormalities sooner. The other patterns don’t match this age- and frequency-specific approach: screening that begins too young (15–24) would lead to unnecessary testing and anxiety; a plan that keeps a wide gap (40–60 every 2 years) underestimates the need for more frequent checks after 40; and not offering CBE at all ignores the intentional, risk-based approach to intermediate-age and older adults.

10. Which of the following is identified as a risk-reduction strategy for breast cancer?

A. Undergo routine mammography starting at age 40

B. Plan for first birth before age 30

C. Limit calcium intake

D. Use tanning beds regularly

Having a first full-term pregnancy before age 30 lowers a woman’s lifetime risk of breast cancer compared with delaying pregnancy or never having children. The protection comes from breast tissue differentiation that occurs during pregnancy and from shortening the overall time a woman spends exposed to hormonal cycles that stimulate breast cell proliferation. This combination reduces the likelihood that cells will undergo malignant changes over a woman’s life. Screening with routine mammography starting at age 40 helps detect cancer early but does not reduce the chance of developing cancer. Limiting calcium intake has no proven protective effect against breast cancer, and regular tanning bed use increases cancer risk rather than decreases it.

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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://femalegynhistoryphysical.examzify.com

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

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