

HESI OBSTETRICS (OB) PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE

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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. An infant born to an HIV-positive mother is admitted to the nursery. What is the first intervention the nurse should perform?**
 - A. Measure the head and chest circumference
 - B. Obtain the infant's footprints
 - C. Bathe the infant with antimicrobial soap
 - D. Administer vitamin K

- 2. A 3-day old newborn is switched from a cow's milk formula to a soy-based formula due to spitting up. What key information should the nurse provide to the mother?**
 - A. The new formula is a coconut milk formula
 - B. Enfamil Formula is needed with diarrhea
 - C. The new formula is a casein protein source
 - D. Similac Soy Isomil Formula is a soy-based formula that contains sucrose

- 3. What action should the nurse take for a prenatal patient presenting with severe abdominal pain and spotting?**
 - A. Schedule an ultrasound
 - B. Monitor vital signs
 - C. Assess the patient immediately and notify the healthcare provider
 - D. Encourage the patient to rest

- 4. A client in her second trimester is interested in using herbal therapy. What is the best response for the nurse?**
 - A. Herbs are a cornerstone of good health
 - B. Touch is therapeutic in relieving discomfort
 - C. Your healthcare provider should direct treatment options
 - D. It is important that you want to take part in your care

- 5. Which assessment finding should the nursery nurse report to the pediatric healthcare provider?**
 - A. Blood glucose level of 45 mg/dl
 - B. Blood pressure of 82/45
 - C. Non-bulging anterior fontanel
 - D. Central cyanosis when crying

- 6. How often should prenatal visits occur during the first 28 weeks of pregnancy?**
- A. Every 2 weeks
 - B. Every 4 weeks
 - C. Every month
 - D. Every 6 weeks
- 7. At what gestational age is Group B Streptococcus screening typically performed?**
- A. 28 to 30 weeks
 - B. 35 to 37 weeks
 - C. 32 to 34 weeks
 - D. 38 to 40 weeks
- 8. During a newborn exam, the nurse identifies crepitus. Which further assessment should be performed?**
- A. Elicit a positive scarf sign on the affected side
 - B. Observe for asymmetrical Moro (startle) reflex
 - C. Watch for swelling of fingers on the affected side
 - D. Note paralysis of affected extremity and muscles
- 9. For a woman with type 2 diabetes who becomes pregnant, what is the most important nursing intervention?**
- A. Describe diet changes that can improve the management of her diabetes
 - B. Inform the client that oral hypoglycemic agents are teratogenic during pregnancy
 - C. Demonstrate self-administration of insulin
 - D. Evaluate the client's ability to do glucose monitoring
- 10. What should the nurse do first for a client receiving epidural anesthesia who begins to experience nausea and becomes pale and clammy?**
- A. Raise the foot of the bed
 - B. Assess for vaginal bleeding
 - C. Evaluate the fetal heart rate
 - D. Take the client's blood pressure

Answers

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

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Explanations

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1. An infant born to an HIV-positive mother is admitted to the nursery. What is the first intervention the nurse should perform?

- A. Measure the head and chest circumference
- B. Obtain the infant's footprints
- C. Bathe the infant with antimicrobial soap**
- D. Administer vitamin K

The first intervention a nurse should perform for an infant born to an HIV-positive mother is to bathe the infant with antimicrobial soap. This action is crucial because it helps to reduce the risk of potential transmission of HIV through contact with maternal blood and body fluids that may be on the infant's skin. Newborns are susceptible to infections, and a thorough bath can clear any contaminants that could pose a health risk. Although obtaining the infant's footprints and administering vitamin K are important procedures following birth, they are not as immediate in addressing the specific concerns with an infant whose mother is HIV-positive. Measuring head and chest circumference, while a standard part of the infant's assessment, does not provide any immediate protection against potential HIV transmission. Thus, initiating the bathing process with antimicrobial soap is the most critical first step to ensure the infant's safety and well-being.

2. A 3-day old newborn is switched from a cow's milk formula to a soy-based formula due to spitting up. What key information should the nurse provide to the mother?

- A. The new formula is a coconut milk formula
- B. Enfamil Formula is needed with diarrhea
- C. The new formula is a casein protein source
- D. Similac Soy Isomil Formula is a soy-based formula that contains sucrose**

The key information to provide to the mother is that Similac Soy Isomil Formula is a soy-based formula that contains sucrose. This choice is significant because it highlights that the formula being used is specifically designed for infants who require a soy-based nutrition alternative. Infants who are switched to soy formulas may have issues with cow's milk protein, and understanding that the new formula is soy-based helps the mother grasp the nutritional adjustments being made for her baby. Moreover, mentioning that it contains sucrose provides insights into the nutrient composition of the formula. Sucrose can be a palatable carbohydrate source for infants and can help with energy needs. While the other options provide varying degrees of information about formulas, they do not directly relate to the specifics of the soy formula being introduced. For instance, stating that the new formula is a casein protein source would be inaccurate since soy formulas are based on soy protein, not casein, while the other options either reference unrelated formulas or specific conditions that may not be applicable in this situation. Understanding this can reassure the mother that she is following the appropriate dietary guidelines for her newborn.

3. What action should the nurse take for a prenatal patient presenting with severe abdominal pain and spotting?

- A. Schedule an ultrasound
- B. Monitor vital signs
- C. Assess the patient immediately and notify the healthcare provider**
- D. Encourage the patient to rest

In the scenario of a prenatal patient experiencing severe abdominal pain and spotting, the priority action for the nurse is to assess the patient immediately and notify the healthcare provider. This approach is crucial because severe abdominal pain and spotting during pregnancy can indicate serious complications, such as an ectopic pregnancy, placental abruption, or miscarriage. Prompt assessment allows the nurse to gather vital information about the patient's condition, such as the severity and location of the pain, the amount and characteristics of the spotting, and any associated symptoms like dizziness or changes in vital signs. This information is vital for the healthcare provider to make informed decisions regarding further diagnostic testing and management. Notifying the healthcare provider immediately ensures that the patient receives timely intervention, which is critical in situations that may threaten the pregnancy or the mother's health. Quick and effective communication with the healthcare team can facilitate necessary interventions, such as imaging studies or other assessments, or potentially urgent care if indicated. While monitoring vital signs is important and would typically be part of the overall assessment, it does not directly address the need for immediate evaluation and intervention in this context. Additionally, scheduling an ultrasound and encouraging the patient to rest are actions that may be appropriate later but do not address the acute nature of the patient's presentation.

4. A client in her second trimester is interested in using herbal therapy. What is the best response for the nurse?

- A. Herbs are a cornerstone of good health
- B. Touch is therapeutic in relieving discomfort
- C. Your healthcare provider should direct treatment options
- D. It is important that you want to take part in your care**

The best response indicates the importance of the client's involvement and desire to participate in her own care. Encouraging open communication about her interest in herbal therapy acknowledges her autonomy and validates her choices as a client, which is essential in a therapeutic nurse-client relationship. This response also sets the stage for a discussion about safety, efficacy, and evidence-based practices. By focusing on the client's interests, it provides an opportunity for the nurse to educate the client about the possible risks and benefits of herbal therapies during pregnancy, emphasizing the importance of working collaboratively with her healthcare provider. This ensures that any treatment options considered—whether traditional or herbal—are safe and appropriate for her specific health needs. While promoting participatory care, it's crucial to discuss that not all herbal remedies are safe during pregnancy, which leads to the importance of the healthcare provider's input in determining suitable treatment options. Therefore, while the response reinforces the client's role in her care, it indirectly supports the need for careful consideration and professional guidance in therapy selection.

5. Which assessment finding should the nursery nurse report to the pediatric healthcare provider?

- A. Blood glucose level of 45 mg/dl
- B. Blood pressure of 82/45
- C. Non-bulging anterior fontanel

D. Central cyanosis when crying

Central cyanosis, particularly when it occurs during crying, is a significant finding that requires immediate attention. It indicates a lack of adequate oxygenation in the blood that can lead to serious complications if not addressed. Unlike peripheral cyanosis, which can be a benign phenomenon often seen in colder temperatures or due to limited blood flow to the extremities, central cyanosis indicates that there are systemic issues that need to be investigated, such as cardiac or respiratory problems. Reporting this finding to the pediatric healthcare provider ensures that the newborn receives appropriate evaluation and intervention, as it may signal underlying congenital heart disease or other respiratory distress. The other choices, while they may warrant assessment and monitoring, do not require reporting in the same urgent manner as central cyanosis. A blood glucose level of 45 mg/dl could be concerning depending on the context and the newborn's symptoms, but without additional clinical signs of distress, it is commonly managed under certain protocols. A blood pressure of 82/45, although on the lower end for a newborn, is sometimes within the scope of acceptable variation based on the infant's age and clinical context. A non-bulging anterior fontanel is actually a normal finding and suggests that there is no increased intracranial pressure, which would be

6. How often should prenatal visits occur during the first 28 weeks of pregnancy?

- A. Every 2 weeks
- B. Every 4 weeks**
- C. Every month
- D. Every 6 weeks

During the first 28 weeks of pregnancy, the recommended frequency for prenatal visits is every four weeks. This schedule allows healthcare providers to monitor the health of both the mother and the developing fetus, addressing any potential complications early while ensuring that the mother receives necessary information and support during this critical period of pregnancy. Every four weeks provides a balanced approach, allowing adequate time for assessments, tests, and education without overwhelming the expectant mother with unnecessary appointments. This frequency also aligns with established clinical guidelines, which emphasize maintaining regular check-ins to monitor the progression of the pregnancy and the overall well-being of both mother and baby. As the pregnancy progresses into the later trimesters, the frequency of visits typically increases to ensure closer monitoring as the due date approaches. This methodical approach ensures that any risks or concerns are managed promptly, optimizing outcomes for both mother and child.

7. At what gestational age is Group B Streptococcus screening typically performed?

- A. 28 to 30 weeks
- B. 35 to 37 weeks**
- C. 32 to 34 weeks
- D. 38 to 40 weeks

Group B Streptococcus (GBS) screening is typically performed between 35 to 37 weeks of gestation. This timing is crucial because it allows for the identification of GBS colonization in pregnant individuals as they approach delivery. Screening at this point in pregnancy is important because the presence of GBS can lead to neonatal infections, particularly during the first week of life. The recommendation is to test during this window because it captures the most relevant period in relation to labor and delivery. Testing too early in the third trimester may not accurately reflect the GBS status at the time of delivery, as colonization can fluctuate over time. This timing ensures that if a pregnant individual is found to be GBS positive, appropriate prophylactic antibiotics can be administered during labor to help reduce the risk of infection to the newborn. This proactive approach has been shown to significantly decrease the incidence of early-onset GBS disease in infants.

8. During a newborn exam, the nurse identifies crepitus. Which further assessment should be performed?

- A. Elicit a positive scarf sign on the affected side
- B. Observe for asymmetrical Moro (startle) reflex**
- C. Watch for swelling of fingers on the affected side
- D. Note paralysis of affected extremity and muscles

Identifying crepitus during a newborn exam can indicate a possible fracture of the clavicle or other bony structures. Observing for an asymmetrical Moro reflex is a crucial step in further assessment because this reflex can help determine if there is an injury to the brachial plexus or the shoulder area that might have resulted from a fracture. The Moro reflex, also known as the startle reflex, is a normal reflex in newborns where they spread their arms and then retract them when they feel a sudden loss of support. An asymmetrical response in this reflex can suggest that there is a neurological issue or injury to one side of the body, which could correlate with the presence of crepitus. In this context, gathering information about the Moro reflex can provide insight into the severity of any potential injury, allowing for appropriate interventions and management if necessary. This focus on neuromuscular function is essential in a comprehensive approach to assessing the newborn following the identification of crepitus.

9. For a woman with type 2 diabetes who becomes pregnant, what is the most important nursing intervention?

A. Describe diet changes that can improve the management of her diabetes

B. Inform the client that oral hypoglycemic agents are teratogenic during pregnancy

C. Demonstrate self-administration of insulin

D. Evaluate the client's ability to do glucose monitoring

When managing a pregnant woman with type 2 diabetes, the most critical nursing intervention is to describe diet changes that can improve the management of her diabetes. Proper dietary management is fundamental to stabilizing blood glucose levels, which is especially important during pregnancy to prevent complications for both the mother and the developing fetus. A balanced diet tailored to control blood sugar can reduce the risks of hyperglycemia and its associated complications, such as fetal macrosomia, preterm birth, and congenital anomalies. Incorporating dietary changes is also essential for promoting overall health and can serve as a foundation upon which other management strategies, such as insulin administration or glucose monitoring, can be built. It's vital that the patient understands which foods can help maintain steady blood sugar levels and how to plan her meals effectively. While the other options are relevant aspects of diabetes management during pregnancy, they typically come into play after addressing dietary modifications. Informing the client about the teratogenic effects of certain oral hypoglycemic agents, demonstrating insulin administration, and evaluating her ability for glucose monitoring are all important activities, but they are secondary to establishing a solid dietary foundation that allows for better diabetes control throughout the pregnancy.

10. What should the nurse do first for a client receiving epidural anesthesia who begins to experience nausea and becomes pale and clammy?

A. Raise the foot of the bed

B. Assess for vaginal bleeding

C. Evaluate the fetal heart rate

D. Take the client's blood pressure

In a scenario where a client receiving epidural anesthesia exhibits nausea and becomes pale and clammy, the most appropriate initial action is to take steps to prevent potential complications related to hypotension. Raising the foot of the bed can help increase venous return to the heart and improve circulation, potentially alleviating the client's symptoms. Epidural anesthesia can lead to a drop in blood pressure due to its effects on the autonomic nervous system. Positioning the patient by raising the legs can promote blood flow back to the thoracic cavity, counteracting the hypotensive effect and providing better perfusion to vital organs, including the placenta. Considering the other options, assessing for vaginal bleeding may be necessary if there are signs of maternal distress, but it is not the immediate priority in this case of suspected hypotension. Evaluating fetal heart rate is also important, but addressing the mother's hemodynamic stability takes precedence to ensure both maternal and fetal wellbeing. While taking the client's blood pressure is crucial, it is more effective to first implement an intervention that can directly improve the situation, such as adjusting her position. Thus, raising the foot of the bed is the critical first step in addressing the client's nausea and pallor.

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://hesiobstetrics.examzify.com>

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

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