

MEDBRIDGE ORTHOPEDIC CLINICAL SPECIALIST (OCS) TEST 1 PRACTICE (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. Which muscle will be weak with anterior interosseous nerve entrapment but not weak with carpal tunnel syndrome?**
 - A. FPL
 - B. FDP (lateral half)
 - C. Pronator Quadratus
 - D. FDS

- 2. Which test assesses iliopsoas tightness?**
 - A. Obers test
 - B. Thomas test
 - C. Patrick's test
 - D. Trendelenburg test

- 3. What condition describes avascular necrosis of the femoral head often seen in corticosteroid use or sickle cell disease?**
 - A. Osteoarthritis of the hip
 - B. Osteoporosis of the femoral neck
 - C. Osteonecrosis (avascular necrosis) of the femoral head
 - D. Trochanteric bursitis

- 4. Which headache type is typically unilateral?**
 - A. Female predominant
 - B. Intense pain
 - C. Radiating pain from back to front
 - D. Unilateral headache

- 5. A 23-year-old male with insidious pain on the radial side of the palm and paresthesias in the thumb, index, and middle finger, worsened by activity such as tennis, is most likely diagnosed with which condition?**
 - A. Anterior interosseous nerve entrapment
 - B. Radial tunnel syndrome
 - C. Pronator teres syndrome
 - D. Posterior interosseous nerve entrapment

- 6. What is a typical mechanism of ACL injuries?**
- A. Direct blow to the knee
 - B. Hyperextension with axial load
 - C. Valgus loading with contact
 - D. Non-contact pivoting with sudden deceleration and change of direction
- 7. Which of the following is NOT one of the carpal tunnel CPR points?**
- A. Shaking hands to relieve symptoms
 - B. Wrist ratio > 0.67
 - C. Symptom severity scale > 1.9
 - D. Phalen's test
- 8. What is a common indication for hip arthroscopy?**
- A. Acetabular fracture
 - B. Osteoarthritis progression
 - C. Displaced femoral neck fracture
 - D. Femoroacetabular impingement (FAI) with labral tear
- 9. What is the typical time frame for early fibrocartilage healing after microfracture in a young athlete?**
- A. 2–4 weeks for initial fibrocartilage formation; remodeling may continue for 2–3 months.
 - B. 4–8 weeks for initial fibrocartilage formation; remodeling may continue for 3–6 months.
 - C. 6–12 weeks for initial fibrocartilage formation; remodeling may continue for 6–12 months.
 - D. 12–24 weeks for initial fibrocartilage formation; remodeling may continue for 12–24 months.
- 10. Which mobilization has NOT been shown to improve heel pain symptoms in plantar fasciitis?**
- A. Cuboid thrust manipulation
 - B. Proximal tibiofibular joint thrust manipulation
 - C. Midtarsal pronation/supination nonthrust manipulation
 - D. Distal tibiofibular joint posterior nonthrust manipulation

Answers

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

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Explanations

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1. Which muscle will be weak with anterior interosseous nerve entrapment but not weak with carpal tunnel syndrome?

- A. FPL
- B. FDP (lateral half)
- C. Pronator Quadratus**
- D. FDS

Anterior interosseous nerve entrapment selectively weakens the deep forearm flexors that this nerve supplies, while carpal tunnel syndrome, which compresses the median nerve at the wrist, does not affect those proximal branches. The muscle in question is innervated solely by the anterior interosseous nerve, so its weakness points to an AIN issue rather than CTS. Pronator quadratus receives its motor input exclusively from the anterior interosseous nerve, making it the best discriminator: it will be weak with AIN entrapment but spared with carpal tunnel syndrome.

2. Which test assesses iliopsoas tightness?

- A. Obers test
- B. Thomas test**
- C. Patrick's test
- D. Trendelenburg test

Assessing hip flexor tightness, specifically iliopsoas, with a simple supine test. In this test the patient lies on their back and one knee is brought to the chest to flatten the lumbar spine. The other leg is allowed to rest on the table. If that leg cannot lie flat on the table and the hip remains flexed (the thigh may rise off the table or the knee cannot fully extend), this indicates a tight iliopsoas on the tested side. A normal result is when the leg on the table lies flat with the knee extended, meaning there is no hip flexion contracture. Other tests target different structures: Obers tests the iliotibial band, Patrick's (FABER) tests hip joint or sacroiliac pathology and hip flexor tightness, and Trendelenburg assesses abductor weakness.

3. What condition describes avascular necrosis of the femoral head often seen in corticosteroid use or sickle cell disease?

- A. Osteoarthritis of the hip
- B. Osteoporosis of the femoral neck
- C. Osteonecrosis (avascular necrosis) of the femoral head**
- D. Trochanteric bursitis

Avascular necrosis of the femoral head occurs when the blood supply to the femoral head is disrupted, causing bone tissue to die and the head to collapse over time. This is classically linked to corticosteroid use and sickle cell disease, which both increase the risk of compromised blood flow to the bone. The scenario fits because those risk factors point to ischemia and subsequent necrosis rather than simple wear-and-tear or inflammatory bursitis. In contrast, osteoarthritis of the hip is a degenerative process of cartilage that leads to joint space narrowing and osteophyte formation, typically in older adults. Osteoporosis of the femoral neck is a density disorder that raises fracture risk but does not describe bone death from loss of blood supply. Trochanteric bursitis involves inflammation of a bursa over the greater trochanter, causing lateral hip pain, not avascular necrosis of the femoral head.

4. Which headache type is typically unilateral?

- A. Female predominant
- B. Intense pain
- C. Radiating pain from back to front

D. Unilateral headache

Lateralization of pain is a key way we describe different headache disorders. The best choice highlights that this kind of headache typically presents on one side. Migraine and cluster headaches are well known for unilateral pain, often localized around the eye or temple in the case of cluster and generally one-sided throbbing in migraine (though the side can vary between attacks). The other options don't define a headache type: being female-predominant describes who is affected more often, not the presentation; intense pain describes severity rather than the syndrome's pattern; radiating pain from back to front isn't the characteristic pattern used to name a headache type. So describing it as unilateral captures the common presentation feature for these primary headaches.

5. A 23-year-old male with insidious pain on the radial side of the palm and paresthesias in the thumb, index, and middle finger, worsened by activity such as tennis, is most likely diagnosed with which condition?

- A. Anterior interosseous nerve entrapment
- B. Radial tunnel syndrome
- C. Pronator teres syndrome**
- D. Posterior interosseous nerve entrapment

Compression of the median nerve at the elbow, specifically under the pronator teres muscle, is the scenario here. When the median nerve is irritated in this location, you get insidious forearm pain and sensory changes in its distribution to the thumb, index, and middle fingers, which can extend to the palm. Repetitive forearm pronation and elbow flexion—like playing tennis—can worsen the pressure under the pronator teres and bring on the symptoms. Why the others don't fit as well: anterior interosseous nerve entrapment affects only motor fibers to deep forearm muscles, so there would be weakness (like a pinch sign) without the sensory symptoms in the digits. posterior interosseous nerve entrapment and radial tunnel syndrome involve the radial nerve and typically produce motor weakness of finger extension or dorsal forearm pain, not the median nerve sensory pattern in the palm and the thumb–middle finger distribution.

6. What is a typical mechanism of ACL injuries?

- A. Direct blow to the knee
- B. Hyperextension with axial load
- C. Valgus loading with contact
- D. Non-contact pivoting with sudden deceleration and change of direction**

The typical mechanism is a non-contact pivoting motion with sudden deceleration and a change of direction. In this scenario, the athlete plants the foot and rapidly twists the knee, generating large anterior tibial shear and rotational forces on the ACL as the body continues to move while the knee is trying to stop. The knee is often near full extension or in slight flexion with a valgus and rotational loading, which places the ACL under peak strain and can lead to tearing even without any direct blow to the knee. This pattern is common in sports that involve cutting, pivoting, and abrupt stops, such as basketball, soccer, and football. While direct impact or hyperextension can injure the ACL, the non-contact pivot-and-deceleration mechanism is the most typical.

7. Which of the following is NOT one of the carpal tunnel CPR points?

- A. Shaking hands to relieve symptoms
- B. Wrist ratio > 0.67
- C. Symptom severity scale > 1.9
- D. Phalen's test**

These carpal tunnel CPR points are a concise set of bedside clues that together help predict carpal tunnel syndrome without nerve testing. Shaking the hands to relieve symptoms is included because patients often report symptom relief with rest or movement, reflecting the intermittent nature of median nerve compression. A wrist ratio greater than 0.67 is included as an anatomical risk indicator—the ratio captures how the wrist's dimensions can predispose to tunnel crowding. A symptom severity scale above 1.9 provides a quantitative measure of how burdensome the symptoms are, which strengthens the prediction. Phalen's test, while a classic provocative maneuver for CTS, isn't part of this particular CPR. It's a diagnostic maneuver that can be positive in CTS but doesn't add independent predictive value within the multivariate rule used to derive the CPR, so it isn't included as one of the CPR points.

8. What is a common indication for hip arthroscopy?

- A. Acetabular fracture
- B. Osteoarthritis progression
- C. Displaced femoral neck fracture
- D. Femoroacetabular impingement (FAI) with labral tear**

The main idea is that hip arthroscopy is most commonly used for intra-articular problems that cause mechanical symptoms, especially femoroacetabular impingement with a labral tear. In FAI, abnormal contact between the femoral head-neck area and the acetabulum irritates and tears the labrum, often with cartilage damage, leading to groin pain and catching or locking sensations. Arthroscopy lets the surgeon address both issues: repair or debridement of the torn labrum and reshaping of the impinging bone (cam osteoplasty or pincer rim trim) to restore smooth joint motion and reduce symptoms. The other scenarios are not typical indications: fractures like an acetabular fracture or a displaced femoral neck fracture require fracture fixation or arthroplasty, not a primary arthroscopic treatment; progression of osteoarthritis is generally not treated with arthroscopy as a primary approach.

9. What is the typical time frame for early fibrocartilage healing after microfracture in a young athlete?

- A. 2–4 weeks for initial fibrocartilage formation; remodeling may continue for 2–3 months.
- B. 4–8 weeks for initial fibrocartilage formation; remodeling may continue for 3–6 months.
- C. 6–12 weeks for initial fibrocartilage formation; remodeling may continue for 6–12 months.**
- D. 12–24 weeks for initial fibrocartilage formation; remodeling may continue for 12–24 months.

The timing being tested is the typical healing timeline after a microfracture procedure. When marrow elements are exposed, a blood clot forms in the defect and mesenchymal cells migrate in to fill the space. These cells differentiate into chondrocyte-like cells and produce fibrocartilaginous tissue. That initial fibrocartilage formation generally begins around six to twelve weeks after surgery. Remodeling and maturation of this repair tissue continue well beyond that, typically extending for six to twelve months as the tissue reorganizes, strengthens, and more closely adapts to the surrounding joint environment. In a young athlete, the healing potential is good, which helps support this general timeline, though individual variation can occur.

10. Which mobilization has NOT been shown to improve heel pain symptoms in plantar fasciitis?

- A. Cuboid thrust manipulation
- B. Proximal tibiofibular joint thrust manipulation
- C. Midtarsal pronation/supination nonthrust manipulation**
- D. Distal tibiofibular joint posterior nonthrust manipulation

Manual therapy for plantar fasciitis aims to modify foot and ankle mechanics to reduce strain on the plantar fascia. Not all mobilizations have proven benefits, and the evidence differs by the joint being treated. The midtarsal joint mobilization focused on pronation and supination, done without thrust, has not consistently shown relief of heel pain in plantar fasciitis. In other words, nonthrust mobilization of the midtarsal joints does not appear to reliably reduce symptoms, even though it may improve midfoot mobility in other conditions. By contrast, mobilizations at nearby joints can influence overall foot mechanics and loading patterns in ways that the plantar fascia responds to more favorably. Techniques like cuboid thrust manipulation and thrust-like or posterior, nonthrust mobilizations at distal and proximal tibiofibular joints have been associated with symptom improvements in this condition, likely because they help restore more optimal alignment and load distribution across the hindfoot and lower leg. So, the mobilization that has not been shown to improve heel pain symptoms is the midtarsal pronation/supination nonthrust manipulation.

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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