

# NREMT TRAUMA PRACTICE EXAM (SAMPLE)

## STUDY GUIDE



## SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR  
THE FULL VERSION STUDY GUIDE

<https://nremttrauma.examzify.com>



**Copyright © 2026 by Examzify - A Kaluba Technologies Inc. product.**

**ALL RIGHTS RESERVED.**

No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.

Notice: Examzify makes every reasonable effort to obtain accurate, complete, and timely information about this product from reliable sources.

SAMPLE

# Table of Contents

|                             |    |
|-----------------------------|----|
| Copyright .....             | 1  |
| Table of Contents .....     | 2  |
| Introduction .....          | 3  |
| How to Use This Guide ..... | 4  |
| Questions .....             | 5  |
| Answers .....               | 8  |
| Explanations .....          | 10 |
| Next Steps .....            | 15 |

SAMPLE

# 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

SAMPLE

- 1. Shock following major trauma is MOST often the result of:**
  - A. spinal injury.
  - B. long bone fractures.
  - C. head injury.
  - D. hemorrhage.
  
- 2. Which finding is a late sign of hypovolemic shock in trauma?**
  - A. Tachycardia with normal blood pressure
  - B. Hypotension (blood pressure drop) with rising heart rate earlier in progression
  - C. Warm skin
  - D. Normal capillary refill
  
- 3. What is a common consideration in geriatric trauma patients?**
  - A. No special considerations
  - B. Younger baseline and higher tolerance
  - C. Only orthopedic injuries matter
  - D. Multiple comorbidities and reduced physiologic reserve altering presentation and management.
  
- 4. Which of the following is considered a significant mechanism of injury that would warrant rapid head-to-toe assessment?**
  - A. A stable patient involved in a low-speed collision.
  - B. An elderly patient who tripped and fell 3 feet.
  - C. A motor vehicle crash at highway speeds with potential ejection.
  - D. A minor laceration to the forearm.
  
- 5. What is the standard approach to controlling external bleeding from an extremity when direct pressure fails?**
  - A. Apply a tourniquet proximal to the wound and reassess distal circulation.
  - B. Immediately perform surgical ligation on scene.
  - C. Use ice and elevation only.
  - D. Apply a dressing and wait for spontaneous clotting.

- 6. During the rapid assessment of a critically-injured patient, what should you assess in the chest?**
- A. Symmetry and pain.
  - B. Rigidity and guarding.
  - C. Distention and guarding.
  - D. Crepitus and distention.
- 7. In suspected knee dislocation with absent distal pulses, what is the recommended course?**
- A. Manually stabilize the knee and assess distal pulses; if pulses are absent, contact medical control for stabilization instructions.
  - B. Immediately realign the knee to restore pulse.
  - C. Remove the limb to relieve compression.
  - D. Apply traction splint to straighten knee.
- 8. Which item is not part of the DCAP-BTLS mnemonic used in the secondary survey?**
- A. Bleeding
  - B. Tenderness
  - C. Lacerations
  - D. Deformities
- 9. Which statement is true regarding airway devices in suspected basilar skull fracture?**
- A. Nasal airways should be avoided.
  - B. Nasal airways are preferred.
  - C. Oropharyngeal airways are contraindicated.
  - D. Cricothyrotomy should be performed immediately if airway compromise is suspected.
- 10. In suspected spinal injury with a responsive but disoriented patient, what is the recommended approach?**
- A. Maintain inline stabilization, monitor airway, and transport with spinal precautions; reassess neuro status regularly
  - B. Remove helmet and immobilize loosely
  - C. Ignore spinal precautions if disoriented
  - D. Wait for full neuro exam

## **Answers**

SAMPLE

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

SAMPLE

## **Explanations**

SAMPLE

## 1. Shock following major trauma is MOST often the result of:

- A. spinal injury.
- B. long bone fractures.
- C. head injury.
- D. hemorrhage.**

Blood loss from injuries is the primary driver of shock after major trauma. When vessels or organs bleed, the circulating blood volume drops, reducing venous return to the heart (preload) and lowering stroke volume and cardiac output. The body tries to compensate with faster heart rate and peripheral vasoconstriction, but ongoing hemorrhage overwhelms those mechanisms and tissue perfusion falls, leading to shock. This is more common than other shock types after trauma because significant bleeding can occur from solid organ lacerations, pelvic fractures, or major vessel injuries, producing a large volume deficit. In contrast, neurogenic shock from spinal or head injuries and obstructive shock from tension pneumothorax or tamponade occur, but these are less frequent overall in blunt trauma. Long bone fractures can bleed, but the amount is typically less than bleeding from abdominal or pelvic sources. So, the best answer reflects that hypovolemic shock from hemorrhage is the most frequent consequence of major trauma, guiding the emphasis on rapid bleeding control and urgent transport.

## 2. Which finding is a late sign of hypovolemic shock in trauma?

- A. Tachycardia with normal blood pressure
- B. Hypotension (blood pressure drop) with rising heart rate earlier in progression**
- C. Warm skin
- D. Normal capillary refill

Hypovolemic shock progresses from compensated to decompensated states, and the late finding is a drop in blood pressure as the body can no longer maintain perfusion. When volume loss becomes severe, the compensatory mechanisms (like increasing heart rate) can no longer keep the systolic pressure up, so hypotension appears. The heart rate is typically elevated by this point, reflecting the body's attempt to maintain cardiac output, but BPs fall despite that effort. Warm, pink skin is not typical in hypovolemia—that usually points to other shock types or late stages where vasodilation occurs. Normal capillary refill suggests perfusion is adequate, which is unlikely in true hypovolemic shock; delayed capillary refill aligns with poor perfusion. So the late sign you'd expect in this scenario is a hypotensive patient with tachycardia as decompensation sets in.

## 3. What is a common consideration in geriatric trauma patients?

- A. No special considerations
- B. Younger baseline and higher tolerance
- C. Only orthopedic injuries matter
- D. Multiple comorbidities and reduced physiologic reserve altering presentation and management.**

When evaluating trauma in older adults, the key idea is that aging reduces physiologic reserve and most patients have multiple chronic conditions that influence how injuries present and how they should be treated. This means that even modest trauma can lead to disproportionate illness, and signs of instability may be muted. Ongoing illnesses and medications—such as heart disease, kidney or liver impairment, diabetes, and anticoagulants or antiplatelets—change both the presentation and the management plan. For example, a patient on anticoagulants may bleed more with a head injury, and fluid resuscitation needs to be balanced to avoid heart failure or pulmonary edema. Frailty and polypharmacy further complicate decisions about imaging, procedures, and dosing. So, the best choice reflects that multiple comorbidities and reduced physiologic reserve alter how geriatric patients present after trauma and how they should be managed. The other options overlook these important factors: there are real special considerations in older adults, baseline tolerance is often lower rather than higher, and trauma in the elderly is not limited to orthopedic injuries alone.

**4. Which of the following is considered a significant mechanism of injury that would warrant rapid head-to-toe assessment?**

- A. A stable patient involved in a low-speed collision.
- B. An elderly patient who tripped and fell 3 feet.
- C. A motor vehicle crash at highway speeds with potential ejection.**
- D. A minor laceration to the forearm.

*Mechanism of injury guides how thoroughly you assess a trauma patient. A high-energy event transfers a lot of energy into the body and can cause serious injuries that aren't immediately obvious, so you perform a rapid head-to-toe assessment to catch hidden life threats and guide urgent care. In a highway-speed motor vehicle crash with potential ejection, the energy involved is substantial. Deceleration, possible blunt trauma from multiple impact sites, and unrestrained movement raise the risk of severe injuries to the head, neck, chest, abdomen, pelvis, and spine. Even if the patient looks stable, there can be internal bleeding or organ injury that you must identify quickly. The other scenarios involve lower-energy mechanisms or less likelihood of multiple hidden injuries: a stable patient after a low-speed crash, an elderly person who fell a short distance (frailty changes risk, but the mechanism itself is not as high-energy as a highway crash), and a minor forearm laceration (not a mechanism that implies widespread injuries).*

**5. What is the standard approach to controlling external bleeding from an extremity when direct pressure fails?**

- A. Apply a tourniquet proximal to the wound and reassess distal circulation.**
- B. Immediately perform surgical ligation on scene.
- C. Use ice and elevation only.
- D. Apply a dressing and wait for spontaneous clotting.

*When direct pressure fails to control external bleeding from a limb, the standard approach is to apply a tourniquet proximal to the wound to stop arterial inflow and control the hemorrhage. Place the tourniquet high on the limb (typically about 2 inches above the injury, away from a joint) and tighten until the bleeding stops and distal circulation is no longer present. After applying it, reassess distal circulation to confirm perfusion has been adequately interrupted and monitor the patient while preparing for transport. If bleeding remains uncontrolled, you may apply another tourniquet proximal to the first, but the priority is to stop the bleed with a tourniquet rather than waiting or relying on other measures. Ice and elevation alone don't stop arterial bleeding, waiting for spontaneous clotting isn't sufficient, and on-scene surgical ligation isn't a standard prehospital approach.*

**6. During the rapid assessment of a critically-injured patient, what should you assess in the chest?**

- A. Symmetry and pain.**
- B. Rigidity and guarding.
- C. Distention and guarding.
- D. Crepitus and distention.

*During a rapid trauma chest assessment, you quickly look for how the chest is moving and where the patient hurts. Symmetry of chest expansion tells you if both lungs are inflating properly; unequal movement can indicate a pneumothorax, flail chest, or other injury that could compromise breathing. Asking about and palpating for chest wall tenderness helps identify rib fractures or other chest injuries that require attention. The other options mix signs that aren't the primary rapid chest indicators. Rigidity and guarding point to abdominal issues, not the chest. Distention and guarding likewise focus on the abdomen. Crepitus can occur with chest injuries but isn't as reliable a quick measure of chest function as symmetry and pain on palpation.*

**7. In suspected knee dislocation with absent distal pulses, what is the recommended course?**

**A. Manually stabilize the knee and assess distal pulses; if pulses are absent, contact medical control for stabilization instructions.**

B. Immediately realign the knee to restore pulse.

C. Remove the limb to relieve compression.

D. Apply traction splint to straighten knee.

*The situation tests recognizing a limb-threatening knee dislocation and the need to protect the leg while arranging definitive care. When a knee dislocation is suspected and distal pulses are absent, the priority is to prevent further injury and preserve any remaining blood flow. The correct approach is to gently stabilize the knee in the position found and immobilize the leg, then rapidly transport while continuing neurovascular checks. If distal pulses are absent, you should not attempt to realign or straighten the knee in the field, because moving the joint can worsen arterial injury, dislodge clots, or cause additional damage to nearby nerves and vessels. Instead, you seek guidance from medical control on stabilization and pursue urgent transport to a facility capable of vascular assessment and possible surgical intervention. Realigning the knee in the field is not appropriate here because the goal isn't to "get the pulse back through manipulation" but to minimize further harm and get definitive care. Removing the limb or using a traction splint isn't indicated for knee dislocations and could cause additional injury.*

**8. Which item is not part of the DCAP-BTLS mnemonic used in the secondary survey?**

**A. Bleeding**

B. Tenderness

C. Lacerations

D. Deformities

*The main idea tested is how the secondary survey looks for injuries using a systematic checklist. DCAP-BTLS stands for Deformities, Contusions, Abrasions, Punctures/Penetrations, Burns, Tenderness, Lacerations, and Swelling. These categories guide you to inspect for broken bones or joints (deformities), bruises (contusions), scrapes (abrasions), puncture wounds (penetrations), burns, sites that are tender on palpation, cuts (lacerations), and swelling. Bleeding, while critically important to control and monitor, is not one of the categories in this mnemonic. You still assess and manage bleeding as part of patient care, but the mnemonic itself is about identifying specific types of injuries seen on the skin and soft tissues or bones. So, bleeding isn't included in the DCAP-BTLS list, making it the item that isn't part of the mnemonic.*

**9. Which statement is true regarding airway devices in suspected basilar skull fracture?**

- A. Nasal airways should be avoided.**
- B. Nasal airways are preferred.
- C. Oropharyngeal airways are contraindicated.
- D. Cricothyrotomy should be performed immediately if airway compromise is suspected.

*In suspected basilar skull fracture, the main idea is to protect the brain while securing the airway, and the route you choose matters because of how fractures at the skull base change what can safely be inserted. Nasal airways should be avoided because a fracture at the base of the skull can create a pathway for the airway device to enter the cranial cavity. Forcing a nasal airway through a basal skull fracture risks intracranial placement, brain injury, and CSF leak, which can have serious consequences. That's why nasal routes are not used in this scenario. Oropharyngeal airways are generally used in an unconscious patient who does not have a gag reflex; they help keep the airway open without risking transnasal entry into the skull. If airway protection is needed in a patient who can't maintain the airway, clinicians will pursue definitive airway management (like endotracheal intubation) rather than rushing to a cricothyrotomy. Cricothyrotomy is a last-resort, rapidly definitive airway when noninvasive methods can't secure ventilation, not something to do immediately simply because airway compromise is suspected. So the statement that nasal airways should be avoided is the true guidance in this context, with oropharyngeal airways used judiciously based on the patient's consciousness and gag reflex, and more invasive steps reserved for when simpler methods fail.*

**10. In suspected spinal injury with a responsive but disoriented patient, what is the recommended approach?**

- A. Maintain inline stabilization, monitor airway, and transport with spinal precautions; reassess neuro status regularly**
- B. Remove helmet and immobilize loosely
- C. Ignore spinal precautions if disoriented
- D. Wait for full neuro exam

*In suspected spinal injury with a responsive but disoriented patient, the priority is to protect the spine while ensuring the airway and ongoing assessment. Maintaining inline stabilization keeps the cervical spine aligned and minimizes movement that could worsen a potential injury during assessment and transport. Keeping the airway under close watch is essential because disorientation can mask evolving breathing problems or airway obstruction, and you want to be ready to intervene if needed. Transport with spinal precautions means securing the patient to spinal precautions (such as a collar and long backboard) to prevent any secondary injury during movement. Reassessing neurological status regularly during transport helps detect changes early so you can adjust care promptly. Why the other approaches aren't appropriate: removing a helmet and immobilizing loosely can permit movement of the spine and compromise stability, increasing the risk of further injury. Ignoring spinal precautions because the patient is disoriented is unsafe since altered mental status does not rule out serious spinal injury. waiting for a full neurological exam isn't practical in the field; you must act with the information you have, preserving spinal precautions and reassessing as you go.*

## 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](mailto:hello@examzify.com).

Or visit your dedicated course page for more study tools and resources:

<https://nremttrauma.examzify.com>

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

SAMPLE