

SENIOR PRACTICUM BASIC PHYSICAL ASSESSMENT PRACTICE TEST (SAMPLE) STUDY GUIDE



Prepare with structure. Pass with confidence



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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. Where would a nurse palpate to assess the occipital lymph nodes during a head and neck assessment?**
 - A. In front of the ears
 - B. Behind the ears
 - C. Below the chin
 - D. At the jawline
- 2. How is the abdomen typically divided during a physical assessment?**
 - A. Into three sections: upper, middle, and lower
 - B. Into four quadrants: right upper, right lower, left upper, and left lower
 - C. Into two halves: left and right
 - D. Into sections based on organ systems
- 3. Which subjective data most strongly indicates an immune deficiency in a client?**
 - A. "I have difficulty sleeping at night."
 - B. "I have persistent headaches throughout the day."
 - C. "Just as I get over a virus, it seems that I get another."
 - D. "I often experience stomach pain after eating."
- 4. What vital sign change may indicate a postoperative hemorrhage?**
 - A. Increased pulse and decreased blood pressure
 - B. Decreased respiration and normal blood pressure
 - C. Stable heart rate and blood pressure
 - D. Decreased pulse and increased respiratory rate
- 5. Which vital sign is NOT typically measured during a basic physical assessment?**
 - A. Body temperature
 - B. Pulse rate
 - C. Blood glucose level
 - D. Respiratory rate

- 6. What hormonal change causes a rise in basal body temperature during the ovulation cycle?**
- A. Increased estrogen
 - B. Increased luteinizing hormone
 - C. Increased progesterone
 - D. Decreased follicle-stimulating hormone
- 7. Which method is commonly used for assessing breath sounds during a physical exam?**
- A. Percussion
 - B. Auscultation
 - C. Observation
 - D. Blood pressure measurement
- 8. Which symptom is typically associated with thrombophlebitis?**
- A. Constipation
 - B. Pain and swelling
 - C. Anemia
 - D. Hypertension
- 9. Which steps are involved in conducting a thorough abdominal assessment?**
- A. Blood pressure check, temperature measurement, and pulse evaluation
 - B. Inspection, auscultation, palpation, and percussion
 - C. Assessing muscle strength and reflexes
 - D. Checking the lungs and heart sounds
- 10. After a total abdominal hysterectomy, what early assessment change might indicate sepsis?**
- A. Heart rate below 90 bpm
 - B. Temperature of 101.8°F (38.8°C)
 - C. Reduced urine output
 - D. Abdominal pain

Answers

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

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Explanations

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1. Where would a nurse palpate to assess the occipital lymph nodes during a head and neck assessment?

- A. In front of the ears
- B. Behind the ears**
- C. Below the chin
- D. At the jawline

The occipital lymph nodes are located at the base of the skull, specifically just behind the ears. When assessing these nodes, the nurse would place their fingers at the back and lower part of the head, near the occipital bone, and press gently to palpate for any swelling or tenderness. This area is significant because the occipital lymph nodes are part of the lymphatic drainage system for the scalp and might become enlarged in response to infections or other diseases. While the other choices refer to areas where other lymph nodes can be assessed—like preauricular nodes in front of the ears, submental nodes below the chin, and mandibular nodes along the jawline—they do not pertain to the occipital lymph nodes specifically. Understanding the exact location of the occipital nodes is crucial for accurate palpation and assessment during a physical examination.

2. How is the abdomen typically divided during a physical assessment?

- A. Into three sections: upper, middle, and lower
- B. Into four quadrants: right upper, right lower, left upper, and left lower**
- C. Into two halves: left and right
- D. Into sections based on organ systems

Dividing the abdomen into four quadrants—right upper, right lower, left upper, and left lower—is a standard practice in physical assessments. This method allows healthcare providers to localize symptoms, identify potential issues, and organize findings systematically. Each of these quadrants contains specific organs, making it easier to correlate complaints with possible underlying causes. For example, pain in the right upper quadrant may suggest issues with the liver or gallbladder, while discomfort in the left lower quadrant might relate to intestinal issues or gynecological concerns. This quadrant-based approach facilitates clear communication among healthcare professionals and aids in effective diagnosis and treatment planning. Other methods of division, such as into three sections or two halves, do not provide the same comprehensive understanding of the abdominal contents and their clinical significance. Similarly, dividing the abdomen based on organ systems lacks the specificity required for physical assessments, making it less practical for immediate clinical evaluation.

3. Which subjective data most strongly indicates an immune deficiency in a client?

- A. "I have difficulty sleeping at night."
- B. "I have persistent headaches throughout the day."
- C. "Just as I get over a virus, it seems that I get another."**
- D. "I often experience stomach pain after eating."

The statement that indicates an immune deficiency most strongly is the one expressing the recurring cycle of illness: "Just as I get over a virus, it seems that I get another." This subjective data reflects a pattern of frequent illnesses, which can suggest that the body's immune system is not functioning effectively. In individuals with an adequate immune response, the body is typically able to recover from infections and viruses, building immunity against them. If someone experiences repeated infections in a short timeframe, it is a sign that their immune system may be compromised or not responding properly to threats. This pattern aligns closely with clinical indicators of immune deficiency, where the body struggles to fend off infections or develop immunity adequately. The other options, while they may indicate some form of health issue, do not specifically point to immune deficiencies. Difficulty sleeping could suggest stress or other health problems, persistent headaches may be related to various conditions or lifestyle factors, and stomach pain after eating might indicate digestive issues or food intolerances rather than an immune response.

4. What vital sign change may indicate a postoperative hemorrhage?

- A. Increased pulse and decreased blood pressure**
- B. Decreased respiration and normal blood pressure
- C. Stable heart rate and blood pressure
- D. Decreased pulse and increased respiratory rate

In the context of postoperative care, an increased pulse combined with a decreased blood pressure is a significant indicator of potential hemorrhage. After surgery, patients are closely monitored for signs of excessive bleeding, as this can occur internally or externally. An increased pulse rate, or tachycardia, often occurs when the body is attempting to compensate for lost blood volume by increasing heart rate to maintain adequate blood circulation and oxygen delivery to vital organs. Concurrently, a decrease in blood pressure suggests that the volume of circulating blood has dropped, which can be due to significant blood loss. This combination of vital sign changes is critical for healthcare providers to recognize, as it can lead to hypovolemic shock if not addressed promptly. In contrast, stable heart rate and blood pressure do not indicate hemorrhage, as they suggest that the patient is maintaining homeostasis. A decreased respiration rate and normal blood pressure may not reflect any significant change in the patient's status, nor do a decreased pulse and increased respiratory rate typically indicate hemorrhage in the postoperative context.

5. Which vital sign is NOT typically measured during a basic physical assessment?

- A. Body temperature
- B. Pulse rate
- C. Blood glucose level**
- D. Respiratory rate

In a basic physical assessment, blood glucose level is not typically classified as a vital sign. Vital signs primarily include body temperature, pulse rate, blood pressure, and respiratory rate. These measurements serve as key indicators of a person's physiological status and are essential in evaluating immediate health and detecting potential medical issues. Body temperature provides information about the body's thermoregulation. Pulse rate offers insights into cardiovascular health, whereas respiratory rate reflects lung and overall respiratory function. Blood glucose level, while important in assessing metabolic status, is not a vital sign; it is usually measured separately, particularly in patients at risk for diabetes or in those presenting with symptoms suggestive of hypoglycemia or hyperglycemia. Therefore, while monitoring blood glucose is crucial in specific clinical situations, it does not fall under the traditional category of vital signs assessed during a routine physical examination.

6. What hormonal change causes a rise in basal body temperature during the ovulation cycle?

- A. Increased estrogen
- B. Increased luteinizing hormone
- C. Increased progesterone**
- D. Decreased follicle-stimulating hormone

The increase in basal body temperature during the ovulation cycle is primarily attributed to increased progesterone levels. Following ovulation, the corpus luteum, which forms from the ruptured follicle, produces progesterone. This hormone plays a crucial role in preparing the endometrium for potential implantation of a fertilized egg and also affects body temperature. Progesterone causes a slight rise in basal body temperature, typically between 0.5 to 1 degree Fahrenheit. This temperature increase is a physiological response that can reflect ovulation and is often used by individuals tracking their fertility. The rise in temperature is not caused by estrogen, luteinizing hormone, or follicle-stimulating hormone in the same direct manner; rather, these hormones regulate different aspects of the menstrual cycle and reproductive process. Estrogen predominates during the follicular phase, and luteinizing hormone spikes just before ovulation, while follicle-stimulating hormone primarily promotes the growth of ovarian follicles and does not significantly influence temperature changes during the luteal phase.

7. Which method is commonly used for assessing breath sounds during a physical exam?

- A. Percussion
- B. Auscultation**
- C. Observation
- D. Blood pressure measurement

Auscultation is the method used for assessing breath sounds during a physical exam. This technique involves using a stethoscope to listen to the sounds made by the lungs and airways as the patient breathes. It allows healthcare providers to evaluate normal and abnormal breath sounds, helping to identify potential respiratory issues such as wheezing, crackles, or decreased breath sounds. The process of auscultation is essential in diagnosing conditions such as pneumonia, asthma, or chronic obstructive pulmonary disease (COPD). It enables the clinician to gather important information regarding the patient's respiratory function and any abnormalities that may be present. In contrast, percussion is a technique used to assess the condition of underlying tissues by tapping on the body surface, often used for evaluating the size and density of organs rather than listening to breath sounds. Observation, while vital in a complete assessment, primarily involves visual inspection rather than auditory evaluation of lung sounds. Blood pressure measurement is unrelated to assessing respiratory function; it focuses on the cardiovascular system.

8. Which symptom is typically associated with thrombophlebitis?

- A. Constipation
- B. Pain and swelling**
- C. Anemia
- D. Hypertension

Thrombophlebitis is characterized by inflammation of a vein, usually in the leg, accompanied by the formation of a blood clot. The typical symptoms of this condition include localized pain and swelling in the affected area due to the inflammatory response and the blockage of blood flow. The pain can feel like a cramp or ache and may be accompanied by visible swelling, redness, and warmth over the affected vein. This clinical presentation is crucial for identifying thrombophlebitis, as these symptoms directly result from the body's attempt to respond to the clot and inflammation in the venous system. Understanding this condition emphasizes the need for prompt recognition and management to prevent complications, such as deep vein thrombosis or pulmonary embolism, which can arise from untreated thrombophlebitis.

9. Which steps are involved in conducting a thorough abdominal assessment?

- A. Blood pressure check, temperature measurement, and pulse evaluation
- B. Inspection, auscultation, palpation, and percussion**
- C. Assessing muscle strength and reflexes
- D. Checking the lungs and heart sounds

The steps involved in conducting a thorough abdominal assessment include inspection, auscultation, palpation, and percussion. This systematic approach allows healthcare professionals to gather comprehensive information about the abdominal organs and structures. Inspection involves visually examining the abdomen for any abnormalities such as distension, asymmetry, or discoloration. Auscultation follows, where the clinician listens for bowel sounds and vascular sounds, which can provide insights into gastrointestinal function or blood flow. Palpation is the next step, where the provider uses their hands to feel for abnormalities, tenderness, or masses in the abdominal region. Finally, percussion is performed to assess the underlying structures by tapping on the abdomen to evaluate tone, resonance, and any potential fluid accumulation. The other options do not pertain to the specific procedures associated with an abdominal assessment. For example, measuring blood pressure, taking temperature, or evaluating pulse does not directly assess abdominal health. Assessing muscle strength and reflexes relates more to neurological evaluation, while checking the lungs and heart sounds pertains to respiratory and cardiac assessments, not the abdomen. Thus, the correct choice highlights the sequential approach necessary for a thorough examination of the abdominal area.

10. After a total abdominal hysterectomy, what early assessment change might indicate sepsis?

- A. Heart rate below 90 bpm
- B. Temperature of 101.8°F (38.8°C)**
- C. Reduced urine output
- D. Abdominal pain

A temperature of 101.8°F (38.8°C) after a total abdominal hysterectomy is a significant finding that could indicate an early change related to sepsis. In the context of postoperative care, fever is often one of the earliest signs of infection, which can progress to sepsis if not identified and addressed promptly. Following surgery, the body experiences physiological changes, and a mild fever can be a normal response to the stress of the procedure. However, even slight elevations above normal body temperature, particularly when they are above 100.4°F (38°C), can warrant further investigation to rule out infections such as wound infections, urinary tract infections, or even more systemic infections that could lead to sepsis. Monitoring vital signs, including temperature, is crucial postoperatively since a marked increase can signify that the body is fighting off an infection. Recognizing a fever coupled with other systemic signs and symptoms can help in the early detection of sepsis, improving patient outcomes through timely intervention. Other options indicate changes but may not be as direct of an early indicator for sepsis compared to an elevated temperature. For instance, a heart rate below 90 bpm would typically not suggest a problem, as it is within normal limits for an

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://srpracticumbasicphysassmt.examzify.com>

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

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