

WOMEN'S HEALTH HISTORY AND PHYSICAL (H&P) PRACTICE EXAM (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. Which threshold defines high risk according to the 5-year Gail model?**
 - A. $\geq 1.7\%$
 - B. $\geq 5\%$
 - C. $\geq 2.5\%$
 - D. $\geq 0.5\%$
- 2. At what age should mammography screening begin for average-risk patients?**
 - A. No later than 40
 - B. By age 50
 - C. At age 60
 - D. After age 45
- 3. Which prior medical history is considered a high-risk criterion for breast cancer?**
 - A. Dense breast tissue
 - B. Atypical ductal hyperplasia
 - C. Prior chest radiation therapy
 - D. 5-year Gail model risk $\geq 1.7\%$
- 4. What synthetic estrogen exposure must be specifically asked about in family history?**
 - A. Whether the patient was exposed to DES in utero
 - B. Whether the patient uses estrogen-containing birth control
 - C. Whether the patient has a family history of breast cancer
 - D. Whether the patient's mother took diethylstilbestrol (DES)
- 5. What is the immediate management for suspected ovarian torsion?**
 - A. Urgent surgical evaluation for detorsion or removal if necrotic.
 - B. Observation with analgesia.
 - C. Antibiotics.
 - D. Hormonal therapy.

- 6. Which factor is specifically associated with cervical cancer risk due to prenatal exposure?**
- A. Immunocompromised status
 - B. In-utero DES exposure
 - C. Prior abnormal results
 - D. Prior CIN2+ or cervical cancer
- 7. Which item is considered most critical to assess at intake in gynecologic history?**
- A. Prior gynecologic infections/surgeries
 - B. Fertility history
 - C. Contraception
 - D. Menopausal status
- 8. Which factor would disqualify a patient from average-risk status for cervical cancer screening?**
- A. Has a cervix
 - B. is asymptomatic
 - C. has no DES exposure
 - D. has DES exposure
- 9. What is the typical folic acid dose for preconception and early pregnancy to reduce neural tube defects?**
- A. 0 mcg
 - B. 50 mcg
 - C. 400-800 mcg
 - D. 4 mg
- 10. Which statement is true about atypical ductal hyperplasia or lobular neoplasia?**
- A. Atypical ductal hyperplasia or lobular neoplasia is a high-risk criterion
 - B. It has no impact on risk assessment
 - C. It is not used in risk assessment
 - D. It is a benign condition with no risk implications

Answers

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

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Explanations

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1. Which threshold defines high risk according to the 5-year Gail model?

- A. ≥1.7%**
- B. ≥5%
- C. ≥2.5%
- D. ≥0.5%

The key idea is knowing the cutoff used by the 5-year Gail model to flag someone as high risk. The Gail model estimates the chance of developing invasive breast cancer in the next five years based on factors such as age, reproductive history, prior breast biopsies, and first-degree relatives with breast cancer. In clinical practice, a five-year risk of about 1.7% or higher is considered high risk, because this level is where discussion of preventive options (like chemoprevention with selective agents or more vigilant screening) is warranted. So the best threshold to define high risk is 1.7% for the next five years.

2. At what age should mammography screening begin for average-risk patients?

- A. No later than 40**
- B. By age 50
- C. At age 60
- D. After age 45

Beginning screening by age 40 for average-risk patients reflects the balance of detecting cancers at a smaller, more treatable stage while avoiding unnecessary testing too early for most women. The idea is that starting by age 40 ensures cancers that develop in the ensuing years can be found earlier, which can improve outcomes. Waiting until age 50 or 60 would delay detection for many cancers that arise in the 40s and early 50s, reducing the potential mortality benefit and allowing tumors to grow larger before discovery. For average-risk individuals—without a strong family history or other high-risk factors—this earlier start is the standard approach in many exam contexts, with proper screening intervals determined by guidelines and shared decision-making.

3. Which prior medical history is considered a high-risk criterion for breast cancer?

- A. Dense breast tissue
- B. Atypical ductal hyperplasia
- C. Prior chest radiation therapy**
- D. 5-year Gail model risk ≥1.7%

Prior chest radiation therapy is a well-established high-risk factor for breast cancer. When radiation is given to the chest, especially at a young age, it increases the lifetime risk of developing breast cancer manyfold because ionizing radiation can induce malignant changes in breast tissue over time. This risk is strong enough that screening guidelines recommend intensified surveillance, typically starting MRI screening years earlier (often 8–10 years after radiation or by age 25, whichever comes later) in addition to mammography, and continuing throughout life. Dense breast tissue, while it can modestly raise relative risk, is considered more a risk modifier than a standalone high-risk history for initiating enhanced screening. Atypical ductal hyperplasia is indeed associated with higher cancer risk, but it is a histologic finding rather than a historical exposure; it guides risk assessment but isn't the classic prior medical history used to label someone as high risk in screening guidelines. The 5-year Gail model risk ≥1.7% reflects calculated risk, not a specific past medical history.

4. What synthetic estrogen exposure must be specifically asked about in family history?

- A. Whether the patient was exposed to DES in utero**
- B. Whether the patient uses estrogen-containing birth control
- C. Whether the patient has a family history of breast cancer
- D. Whether the patient's mother took diethylstilbestrol (DES)

In family history and exposure screening, some prenatal exposures have distinct implications that must be asked about directly. Diethylstilbestrol (DES) is a synthetic estrogen that was prescribed to pregnant women in the past. If a patient was exposed to DES in utero, she has specific risks for reproductive tract anomalies and certain cancers, notably vaginal and cervical clear cell adenocarcinoma. Because these risks are tied to fetal exposure, the most precise question is whether the patient was exposed to DES while in the womb. Estrogen-containing birth control relates to current medication use rather than a prenatal exposure with this particular risk profile. A general family history of breast cancer doesn't identify DES exposure. Asking whether the mother took DES is related but indirect; the clearest, most direct way to capture this risk is asking the patient about in utero DES exposure herself.

5. What is the immediate management for suspected ovarian torsion?

- A. Urgent surgical evaluation for detorsion or removal if necrotic.**
- B. Observation with analgesia.
- C. Antibiotics.
- D. Hormonal therapy.

Ovarian torsion is a surgical emergency because twisting of the ovary and its vascular pedicle rapidly cuts off blood flow, risking ovary viability. The immediate management is urgent surgical evaluation with detorsion to restore perfusion and assess viability. If the ovary appears viable after detorsion, it is typically preserved; removal is reserved for nonviable, necrotic tissue. Delaying for observation or treating with antibiotics or hormonal therapy does not address the twisting or restore blood flow, and analgesia alone may delay diagnosis. While imaging can support suspicion, it should not delay operative exploration because time is critical to prevent irreversible tissue damage.

6. Which factor is specifically associated with cervical cancer risk due to prenatal exposure?

- A. Immunocompromised status
- B. In-utero DES exposure**
- C. Prior abnormal results
- D. Prior CIN2+ or cervical cancer

Prenatal exposure to diethylstilbestrol (DES) is the factor specifically tied to cancer risk from exposure before birth. DES was given to some pregnant women in the mid-20th century to prevent miscarriage, but it disrupts the development of fetal Mullerian-derived tissues, leading to structural changes in the cervix and vagina and a markedly increased risk of certain cancers, notably clear cell adenocarcinoma of the vagina and cervix, in the exposed offspring. This risk arises from exposure in utero, not from immune status or prior cervical disease. The other options involve factors related to the individual's immune system or past cytology, which do not reflect prenatal exposure.

7. Which item is considered most critical to assess at intake in gynecologic history?

- A. Prior gynecologic infections/surgeries
- B. Fertility history**
- C. Contraception
- D. Menopausal status

Understanding fertility history at intake shapes the entire gynecologic care plan. It captures not only past pregnancies and outcomes (live birth, abortion, miscarriage) but also any infertility issues and, crucially, the patient's current reproductive goals. If a patient desires pregnancy, the evaluation focus shifts toward conceiving strategies, timing, and avoiding teratogens, and it prompts earlier pregnancy testing when indicated. If a patient does not want children or wants to delay pregnancy, contraception needs, methods, and counseling become central, and certain treatments may be chosen or avoided to align with that goal. This single piece of information frames how you interpret symptoms, what tests or imaging are appropriate, and which treatments are most suitable given the patient's reproductive plans. While prior infections/surgeries, contraception use, and menopausal status are important pieces, fertility history ties them together and directly guides immediate management and counseling.

8. Which factor would disqualify a patient from average-risk status for cervical cancer screening?

- A. Has a cervix
- B. is asymptomatic
- C. has no DES exposure
- D. has DES exposure**

Risk level for cervical cancer screening depends on factors that raise or lower the likelihood of cervical pathology. DES exposure in utero is a known risk factor because it's linked to vaginal and cervical abnormalities and a higher risk of certain cancers. Because of this, someone with DES exposure would not be considered average-risk and would follow higher-risk screening guidelines. The other points listed don't move someone out of average risk: having a cervix is necessary to do cervical screening, being asymptomatic is typical for screening tests, and no DES exposure keeps the person in the average-risk category.

9. What is the typical folic acid dose for preconception and early pregnancy to reduce neural tube defects?

- A. 0 mcg
- B. 50 mcg
- C. 400-800 mcg**
- D. 4 mg

Folic acid helps the neural tube develop properly very early in pregnancy, often before a woman knows she's pregnant. Because the tube closes by about 28 days after conception, starting supplementation preconception and continuing into early pregnancy reduces the risk of neural tube defects. The typical preventive dose is 400–800 micrograms per day, which can be taken as a vitamin supplement or as part of a fortified multivitamin. Zero intake obviously provides no protection, and 50 micrograms is below the standard preventive level. Four milligrams (4000 micrograms) daily is not the usual dose for most women; it's reserved for those at high risk (such as a prior neural tube defect-affected pregnancy or certain medical conditions) where a higher dose may be indicated.

10. Which statement is true about atypical ductal hyperplasia or lobular neoplasia?

- A. Atypical ductal hyperplasia or lobular neoplasia is a high-risk criterion
- B. It has no impact on risk assessment
- C. It is not used in risk assessment
- D. It is a benign condition with no risk implications

Atypical ductal hyperplasia and lobular neoplasia are considered high-risk lesions in breast pathology. They are not cancers themselves, but their presence on biopsy signals a substantially increased probability of developing breast cancer in the future. Because of this elevated risk, they are incorporated into risk assessments and guide management decisions, including closer imaging surveillance and consideration of risk-reducing strategies. In practice, finding ADH or lobular neoplasia on a biopsy often prompts closer follow-up and discussion about chemoprevention, and sometimes an excisional biopsy is performed to exclude any occult cancer. Their status as high-risk findings is why this statement is true: these conditions carry risk implications and are used in risk assessment, rather than being benign with no impact.

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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://womenshealthhandp.examzify.com>

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

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