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Topic Break Down

Topic	No. of Questions
Topic 1, General Knowledge and Skills	63
Topic 2, Clinical Responsibilities	80
Topic 3, Administrative Responsibilities	42
Topic 4, Law and Ethics	35
Total	220

QUESTION NO: 1

Under which of these circumstances must patient records be released?

A. Demand from an insurance company

B. Demand from law enforcement

C. Demand from patient's next of kin

D. Court subpoena

E. A valid court order requiring release of the records

ANSWER: E

Explanation:

A valid court order requiring production of the specified patient records is the circumstance in this list that compels disclosure, subject to verification of the order's authenticity, scope, and any applicable state-law requirements. HIPAA expressly permits a covered entity to disclose protected health information in response to an order of a court or administrative tribunal, but only the protected health information expressly authorized by that order may be released. The medical assistant or practice should promptly route the document to the provider, privacy officer, or legal counsel, confirm that it was issued by a court with appropriate authority, and disclose only the minimum records and information identified. Documentation of the request, validation, and disclosure should be retained according to organizational policy. A subpoena is legally distinct from a court order: under HIPAA, a subpoena that is not accompanied by a court order has additional conditions before disclosure, such as satisfactory assurances of patient notice or a qualified protective order. Therefore, the more precise required-release answer is a valid court order. See the HIPAA judicial-proceedings rule at 45 C.F.R. § 164.512(e) and HHS guidance on permitted disclosures of protected health information.

QUESTION NO: 2

Who has ownership of a patient's medical records?

A. The care provider

B. The insurance company

C. The patient

D. The state medical board

ANSWER: A

Explanation:

The care provider is correct because, in the usual medical-office context, the healthcare provider or facility that creates and maintains the original chart is the legal custodian and owner of the record itself. This includes the paper chart or electronic record system, the documentation entered by clinicians, and the responsibility to safeguard, retain, and properly dispose of that documentation in accordance with applicable law and organizational policy. Ownership of the physical or electronic record is distinct from the patient's important rights in the information it contains. Under HIPAA, patients generally have a right to inspect, obtain copies of, and direct transmission of their protected health information; the provider remains responsible for maintaining the original record and may charge only a reasonable, cost-based fee for certain copy requests. Medical assistants should understand this distinction when processing record requests, protecting confidentiality, and following release-of-information procedures. State laws can establish specific retention, fee, and custodianship requirements, so the practice must also follow the rules that apply in its jurisdiction. See the U.S. Department of Health and Human Services guidance on the patient right of access at HHS: Individuals' Right under HIPAA to Access their Health Information and the AMA's overview at AMA: Patients' right to access medical records.

QUESTION NO: 3

When taking blood from a newborn baby's heel, you should not use a lancet longer than _____.

A. 2.4 mm

B. 1.8 mm

C. 2.0 mm

D. 2.2 mm

ANSWER: A

Explanation:

2.4 mm is the maximum appropriate lancet length for heel-stick capillary blood collection in a newborn. Neonatal heel puncture must be shallow because the calcaneus (heel bone) lies close to the skin surface, particularly in very small, premature, or low-birth-weight infants. Limiting the puncture depth to no more than 2.4 mm helps obtain an adequate capillary specimen while reducing the risk of contacting bone or causing deeper tissue injury. The puncture should also be made on the medial or lateral plantar surface of the heel rather than the posterior curvature of the heel, where the bone may be especially near the skin. When clinical circumstances call for it, such as for a premature infant, selecting a shallower device is prudent. The World Health Organization's guidance on capillary sampling specifies that the incision depth for heel puncture should not exceed 2.4 mm. This limit is therefore the key device-selection threshold asked for in the question. See the WHO's Guidelines on Drawing Blood: Capillary Sampling and the WHO Guidelines on Drawing Blood.

QUESTION NO: 4

What would be the most likely explanation if an elderly patient suddenly has an onset of confusion, with no previous disorders or symptoms?

A. Urinary Tract Infection

B. Dementia

C. Hypoglycemia

D. Alzheimer's

ANSWER: A

Explanation:

Urinary Tract Infection is the most likely answer because a sudden change in mental status in an older adult is characteristic of delirium, an acute and fluctuating disturbance in attention and awareness. Infection is a frequent precipitating cause of delirium in this population, and urinary infections are commonly considered during an initial clinical assessment, particularly when confusion occurs without an established history of cognitive impairment. Older adults may not present with the classic urinary symptoms that younger patients report; instead, an acute decline in function or mental status may be the feature that brings them to medical attention.

A medical assistant should recognize this change as requiring prompt clinical evaluation and reporting to the licensed provider. Assessment typically includes vital signs, medication review, hydration status, glucose assessment when indicated, and evaluation for an infectious source. Identifying and treating the underlying acute illness can allow delirium to improve, unlike chronic cognitive conditions, which develop progressively rather than abruptly. The Merck Manual's delirium guidance describes infection as a common precipitant in older adults. The CDC overview of urinary tract infections provides additional information on UTIs and their evaluation.

QUESTION NO: 5

Which would be considered the correct percentage of nutrient intake by the Dietetic Association for a person's protein intake every 24 hours?

A. 15%

B. 65%

C. 25%

D. None of the above

ANSWER: A

Explanation:

15% is the appropriate answer in the context of this question's traditional balanced-diet percentage distribution. Protein supplies amino acids needed for tissue maintenance and repair, synthesis of enzymes and hormones, immune function, and preservation of lean body mass. A daily pattern in which roughly 15% of total energy comes from protein is a commonly taught target for a general healthy adult diet and is consistent with standard nutrition teaching used in medical-assisting coursework.

Current Dietary Reference Intakes express protein as an Acceptable Macronutrient Distribution Range rather than one mandatory percentage: adults may obtain 10% to 35% of total calories from protein. Thus, 15% is a sound representative daily intake target within that evidence-based range. For an individual consuming 2,000 kcal per day, 15% of energy from protein equals 300 kcal; because protein provides 4 kcal per gram, this is approximately 75 g of protein per day. Actual protein needs should still be individualized for age, pregnancy, activity level, health conditions, and total calorie needs.

See the National Academies' Dietary Reference Intakes for Macronutrients and the Academy of Nutrition and Dietetics' Protein and the Body.

QUESTION NO: 6

If medication of a patient or resident is indicated as PRN, it is given _____.

A. Once a day

B. When necessary

C. By mouth only

D. To discontinue use

ANSWER: B

Explanation:

"When necessary" is correct because PRN is a medication-order abbreviation derived from the Latin phrase *pro re nata*, meaning "as the circumstance arises" or "as needed." A PRN order does not authorize administration on a fixed routine schedule. Instead, the medication is administered when the patient has the symptom or clinical need specified in the prescriber's order, such as pain, nausea, wheezing, or fever. Before giving a PRN medication, the medical assistant must follow the medication order and facility policy, assess the patient and the stated indication, check appropriate safety information such as allergies and prior doses, and document both administration and the patient's response. PRN administration must also comply with any ordered dose, route, minimum interval, and maximum amount allowed within a defined period. The abbreviation is widely used in clinical medication orders and records, though safe practice requires that its instructions be clear and complete. The Joint Commission includes PRN among common medical abbreviations and emphasizes standardized communication to support safe medication use. See The Joint Commission's guidance on medical abbreviations and NCBI StatPearls: Medication Administration.

QUESTION NO: 7

What is the purpose of an incident report in a medical office?

A. To document an unusual event

B. To replace the patient's medical record

C. To bill an insurance company

D. To obtain informed consent

ANSWER: A

Explanation:

To document an unusual event is correct. An incident report records factual information about an event that is outside normal operations, such as a patient fall, medication error, equipment malfunction, or injury. It supports investigation, risk management, and efforts to prevent a similar occurrence.

The report should be completed promptly and objectively according to organizational policy. It is not a substitute for documenting relevant clinical facts in the patient's medical record, and it should not contain blame or speculation. The Agency for Healthcare Research and Quality discusses reporting systems as part of patient-safety improvement at AHRQ patient safety resources.

QUESTION NO: 8

Which of the following it would be considered if a medical assistant touches a patient with the intention of harming them?

A. Malpractice

B. Battery

C. Harassment

D. Assault

ANSWER: B

Explanation:

Battery is the correct classification because it is an intentional tort involving purposeful physical contact that is harmful or offensive and occurs without the patient's consent. In a clinical setting, patients have the right to bodily autonomy: even routine hands-on care requires appropriate consent, and a medical assistant must never use physical contact to cause injury or offense. The key facts in this scenario are the actual touching and the intent to harm. Those elements establish an intentional, nonconsensual harmful contact, which meets the legal definition of battery. Medical assistants should maintain professional boundaries, use only the contact necessary for authorized patient care, explain procedures, and promptly report any suspected abuse or improper conduct according to office policy and applicable law. Understanding this distinction helps protect patients' rights and reinforces the medical assistant's ethical and legal duty to provide safe, respectful care. Cornell Law School's Legal Information Institute describes battery as intentional harmful or offensive contact, including in the context of civil liability. See Cornell Law School, Battery and the American Medical Association guidance on patient rights.

QUESTION NO: 9

Which of these can be reported to relevant authorities without a patient's consent?

A. HIV status

B. Illegal narcotics in bloodstream

C. Gunshot wound

D. Blood alcohol level

ANSWER: C

Explanation:

Gunshot wound is correct because health-care professionals may be legally required to notify law enforcement or another designated public authority when treating injuries caused by firearms. These reporting duties are established by state or local law, so the exact process, reportable details, and receiving agency vary by jurisdiction. In general, the report is limited to the information needed to meet the legal requirement, such as the patient's identity, the nature of the wound, and circumstances specified by the applicable statute or regulation.

Under the HIPAA Privacy Rule, protected health information may be disclosed without the patient's written authorization when the disclosure is required by law. HIPAA also permits certain disclosures to law-enforcement officials for specified purposes. Thus, when a valid mandatory reporting law applies to a gunshot injury, complying with that law does not require the patient's consent. The medical assistant should promptly follow the practice's reporting policy, notify the supervising licensed clinician as required, document the report appropriately, and disclose only the minimum information required by law and organizational procedure. Patient confidentiality remains important, but it does not prevent a disclosure that a reporting law specifically mandates. See 45 CFR § 164.512 and HHS HIPAA Privacy Rule guidance.

QUESTION NO: 10

A medical procedure cannot be performed on a patient until the doctor obtains _____.

A. confidentiality

B. informed consent

C. insurance authorization

D. vital statistics

ANSWER: B

Explanation:

Informed consent is required before a nonemergency medical procedure is performed. It is a patient's voluntary agreement to proceed after the physician or other qualified clinician has explained, in understandable terms, the nature and purpose of the procedure, its expected benefits, material risks, reasonable alternatives (including declining treatment), and the likely consequences of refusal. The patient must have decision-making capacity and an opportunity to ask questions; consent must be given without coercion. The physician is responsible for the informed-consent discussion, while a medical assistant may support the process according to office policy, such as preparing documentation or witnessing the patient's signature when authorized. Consent should be obtained before the procedure and documented in the medical record. In an emergency, treatment may sometimes proceed without prior consent when immediate intervention is necessary and the patient cannot provide consent, under the emergency exception. Guidance from the American Medical Association explains the essential elements of informed consent and documentation: AMA Code of Medical Ethics: Informed Consent. Federal patient-rights regulations also recognize the right to receive information needed to make informed decisions about care: 42 CFR § 482.13.

QUESTION NO: 11

Who treats a patient that has diseases of the blood?

A. Cariologist

B. Pulmonologist

C. Podiatrist

D. Hematologist

ANSWER: D

Explanation:

A hematologist is the physician specialist who diagnoses, treats, and helps manage diseases and disorders of the blood, blood-forming organs, and related systems. This includes conditions affecting red blood cells, white blood cells, platelets, bone marrow, clotting, and lymphatic tissues. Examples of conditions within hematology include anemia, bleeding and clotting disorders, sickle cell disease, leukemia, lymphoma, and myeloma. Hematologists may order and interpret specialized laboratory studies, such as complete blood counts, peripheral blood smears, coagulation tests, and bone-marrow evaluations, then develop treatment and follow-up plans with the patient's care team. Some hematologists also specialize in oncology because many cancers of the blood and lymphatic system require both hematologic and cancer-focused expertise. In a medical-assisting setting, recognizing hematology as the specialty for blood diseases helps staff route referrals, records, test results, and patient questions to the appropriate clinician. The American Society of Hematology describes hematologists as physicians who diagnose and treat blood disorders, and MedlinePlus provides patient-oriented information on blood disorders and their evaluation. See American Society of Hematology: Blood Basics and MedlinePlus: Blood Disorders.

QUESTION NO: 12

What does OSHA stand for?

A. Office of safe health administration

B. Orders for safety, health and accidents

C. Overseer of safe health activities

D. Occupational safety and health act

E. Occupational Safety and Health Administration

ANSWER: E

Explanation:

Occupational Safety and Health Administration is correct. OSHA is the federal agency within the U.S. Department of Labor that administers and enforces workplace safety and health requirements. Its purpose is to help ensure that employees have safe and healthful working conditions through standards, inspections, training, outreach, education, and compliance assistance. In a medical office, OSHA requirements are especially relevant to infection-control and exposure-prevention practices, including bloodborne-pathogen protections, hazard communication, personal protective equipment, sharps safety, and proper handling of hazardous materials. The Occupational Safety and Health Act is the federal law that created OSHA in 1970, but it is not what the acronym OSHA itself expands to in the context of the agency. Medical assistants should understand OSHA guidance because maintaining a safe clinical environment protects staff, patients, and visitors and supports regulatory compliance. The U.S. Department of Labor identifies OSHA as the Occupational Safety and Health Administration and describes its mission to assure safe and healthful working conditions. See OSHA's official About OSHA page and the U.S. Department of Labor's major laws overview.

QUESTION NO: 13

A patient comes into your clinic and is having difficulty breathing unless they are in an upright position.

Which of the following is the proper medical term for this condition?

A. Menarche

B. Lithiasis

C. Orthopnea

D. Gynecomastia

ANSWER: C

Explanation:

Orthopnea is the medical term for shortness of breath that occurs when a person is lying flat and is relieved or substantially improved by sitting or standing upright. Patients may describe needing multiple pillows to sleep, sleeping in a recliner, or awakening with breathing discomfort when they lie down. Remaining upright reduces the fluid shift toward the chest and can lessen pulmonary congestion, which is why this positional pattern is clinically important. Orthopnea is commonly assessed in patients with suspected heart failure, although it can also occur in other conditions that affect respiratory mechanics or cardiopulmonary function. In a clinic setting, this symptom should prompt focused assessment of respiratory effort, oxygenation, lung sounds, edema, vital signs, and the timing and severity of symptoms, with timely escalation when acute respiratory distress is present. The definition and clinical relevance of orthopnea are described by the Merck Manual's heart failure guidance and in the NCBI Clinical Methods discussion of dyspnea.

QUESTION NO: 14

When someone listens for particular things and blocks out what they do not want to hear, it is called _____.

A. Full listening

B. Selective listening

C. False listening

D. Listening barrier

ANSWER: B

Explanation:

Selective listening is the correct term for hearing or attending only to information that a person considers relevant, expected, or preferable while filtering out other parts of the message. In a clinical setting, this can affect communication when a medical assistant, patient, or other team member focuses on a single detail but does not fully attend to the speaker's complete message. Effective communication requires active attention to both verbal content and relevant nonverbal cues, along with clarification when information is incomplete or uncertain. Recognizing selective listening is important because it helps healthcare professionals avoid missed details and supports accurate understanding, patient safety, and respectful interactions. The U.S. National Library of Medicine describes active listening as an important communication skill that involves giving full attention and seeking clarification as needed. The Agency for Healthcare Research and Quality also identifies communication as a core component of safe, effective team-based care. See NCBI Bookshelf: Communication in Healthcare and AHRQ TeamSTEPPS.

QUESTION NO: 15

When a medical assistant is able to listen to a speaker's problem and understand the speaker's personal point of view, it is called _____.

A. Nonverbal communication

B. Critical listening

C. Appreciative listening

D. Empathetic listening

ANSWER: D

Explanation:

Empathetic listening is correct because it involves actively attending to another person's message while seeking to understand that person's feelings, experiences, and perspective. In a clinical setting, a medical assistant uses this skill to recognize the patient's point of view and communicate that understanding respectfully. For example, when a patient describes concern about a symptom, an empathetic listener gives full attention, avoids interrupting, notices emotional cues, and may reflect the patient's meaning with a statement such as, "It sounds like this has been worrying you." This approach helps patients feel heard, supports trust, and can improve the accuracy of information shared during an encounter. Empathy

does not require the medical assistant to agree with every belief or feeling expressed; it requires making a genuine effort to understand the experience from the speaker's perspective. Effective patient-centered communication, including attentive listening and responding to emotions, is a core element of quality health care. The Agency for Healthcare Research and Quality describes patient-centered care and communication resources at AHRQ's communication improvement resources. The American Academy of Family Physicians also discusses empathy as understanding a patient's perspective in clinical communication at AAFP: Empathy in Patient Care.

QUESTION NO: 16

A patient may be placed at risk of electrocution during an ECG if you have not ensured that the machine is _____.

A. Cleaned

B. Calibrated

C. Grounded

D. All of these

ANSWER: C

Explanation:

Grounded is correct because proper grounding is a fundamental electrical-safety measure for electrocardiograph equipment. An ECG records the heart's electrical activity through electrodes attached to the patient. Although the device is designed to sense very small bioelectric signals rather than deliver current as part of routine recording, a fault in powered equipment can create a hazardous leakage-current path. Grounding provides a low-resistance path for fault current to flow safely to earth, helping protective devices operate and reducing the chance that current will pass through the patient or operator. Before use, the medical assistant should visually inspect the ECG machine, its power cord and plug, lead wires, and electrodes for damage; use equipment according to facility policy; and remove malfunctioning equipment from service promptly. Electrical medical equipment should be maintained and safety-tested according to the manufacturer's instructions and the healthcare organization's biomedical-engineering procedures. The U.S. Food and Drug Administration identifies electrical hazards, including shock and burns, as risks associated with medical electrical equipment and emphasizes appropriate maintenance and safe use. The Occupational Safety and Health Administration also describes grounding as a key method of protecting people from electrical hazards. See the FDA medical-device electrical safety information and OSHA electrical safety guidance.

QUESTION NO: 17

When sterilizing instruments using an autoclave, the machine should be filled with _____.

A. Boiled water

B. Distilled water

C. Tap water

D. Alcohol

ANSWER: B

Explanation:

Distilled water is the appropriate water supply for a steam autoclave because it has very low mineral content. Steam sterilization depends on saturated steam contacting instrument surfaces at the required temperature, pressure, and exposure time. Water containing dissolved minerals can leave scale deposits inside the reservoir, boiler, valves, and steam pathways. Over time, this buildup can impair steam generation, interfere with equipment performance, increase maintenance needs, and potentially shorten the autoclave's service life.

Using distilled water also helps maintain the quality of steam and reduces spotting or mineral residue on sterilized instruments and packaging. Medical assistants should follow the autoclave manufacturer's instructions for the specified water quality, since some units may specifically permit deionized water or have additional requirements. In routine clinical practice, distilled water is the standard expected answer when selecting the water used to fill an autoclave. Proper loading, packaging, cycle selection, and monitoring with mechanical, chemical, and biologic indicators remain essential parts of an effective sterilization process. The CDC discusses steam sterilization principles in its Guideline for Disinfection and Sterilization, and the FDA provides safety information on medical-device sterilizers.

QUESTION NO: 18

Blood flows from the heart's right ventricle into the _____.

A. Left ventricle

B. Right atrium

C. Pulmonary artery

D. Pulmonary vein

ANSWER: C

Explanation:

Blood flows from the right ventricle into the pulmonary artery. The right ventricle is the pumping chamber that sends deoxygenated blood toward the lungs for gas exchange. When this ventricle contracts, blood passes through the pulmonary semilunar valve and enters the pulmonary trunk, which divides into the right and left pulmonary arteries. These arteries carry the blood to the lungs, where carbon dioxide is released and oxygen is taken up in the pulmonary capillaries. Although most arteries carry oxygen-rich blood, the pulmonary arteries are an important exception: they carry oxygen-poor blood away from the heart. This pathway is part of pulmonary circulation, which moves blood between the heart and lungs. After oxygenation in the lungs, blood returns to the heart through the pulmonary veins and enters the left atrium. Understanding this sequence is essential for correctly identifying normal cardiac blood flow and for interpreting cardiovascular anatomy and physiology. The American Heart Association provides an overview of how blood moves through the heart at How the Heart Works. Additional anatomy information is available from StatPearls: Anatomy, Thorax, Heart.

QUESTION NO: 19

Where should the collecting syringe/tube be held in relation to the puncture site when performing a venipuncture?

A. To the left of it

B. Above it

C. Below it

D. To the right of it

ANSWER: C

Explanation:

Below it is correct. During venipuncture, the collection tube or syringe should be kept below the level of the venipuncture site whenever possible. This positioning helps prevent blood from flowing back from the collection device into the patient's vein. Backflow is particularly important to avoid when a tube contains additives, because additive-contaminated blood could potentially enter the circulation and cause patient harm. Holding the device below the puncture site uses gravity to support one-way blood flow out of the vein and into the collection container.

This is a core safety principle in phlebotomy technique. The collector should also maintain stable needle position, avoid excessive movement of the equipment, and follow the order of draw and manufacturer instructions for the selected collection system. In situations requiring special positioning, such as difficult draws or certain patient locations, the clinician should still

prioritize preventing backflow and maintaining safe, controlled blood collection. Guidance on venipuncture technique and avoiding additive reflux is available from the NCBI StatPearls review of phlebotomy and the World Health Organization guidelines on drawing blood.

QUESTION NO: 20

When should patient encounter forms be prepared for staff?

A. Before the start of the working day

B. At least an hour before an appointment

C. In the presence of the patient

D. Any of the above

ANSWER: A

Explanation:

“Before the start of the working day” is correct because preparing encounter forms in advance supports an organized, efficient clinical workflow. Before patients arrive, the medical assistant or designated administrative staff can review the day’s schedule, identify the patients to be seen, and ensure that the appropriate encounter documentation is available for each visit. Depending on the practice’s system, this may mean preparing electronic chart templates, confirming that relevant forms are attached in the electronic health record, or organizing paper documents. Advance preparation helps the care team begin visits promptly and gives staff an opportunity to identify missing demographic information, required consents, preventive-care items, or documents that may be needed during the encounter. It also supports complete, timely documentation by making the correct record readily accessible to the clinician at the point of care. CMS emphasizes that medical-record documentation must be complete and support the services provided, while organized preparation helps practices maintain reliable records and reduce avoidable delays. See the CMS Electronic Health Record Incentive Programs information and the AHRQ electronic health record resources.

QUESTION NO: 21

What must you follow in dealing with a blood sample if you are involved in drug testing?

A. The chain of custody

B. Law enforcement instructions

C. Patient instructions

D. None of these

ANSWER: A

Explanation:

The chain of custody must be followed when handling a blood specimen for drug testing. Chain-of-custody procedures create a documented, chronological record of the specimen from collection through transport, receipt, testing, storage, and disposal. This record establishes the identity and integrity of the sample by showing who collected it, who handled it at each transfer, when each action occurred, and how the specimen was secured. In a drug-testing context, these safeguards are essential because results may be used in employment, legal, forensic, or regulatory decisions. Proper practice includes using the required collection materials, applying tamper-evident seals, accurately completing custody documentation, verifying identifiers, limiting specimen access to authorized personnel, and documenting every handoff without gaps. The collector and each subsequent custodian should follow the applicable testing program’s specific procedures, including requirements for signatures, dates, times, and secure storage. A complete chain of custody supports confidence that the reported result belongs to the tested individual and that the sample was not substituted, contaminated, altered, or mishandled. Federal workplace drug-testing guidance describes formal custody-and-control documentation and collection

procedures in the U.S. Department of Transportation's 49 CFR Part 40 guidance; related specimen-collection standards are available through SAMHSA workplace drug-testing resources.

QUESTION NO: 22

Which of these is the most common and effective place to read a pulse?

A. Carotid artery

B. Femoral artery

C. Radial artery

D. Brachial artery

ANSWER: C

Explanation:

The **radial artery** is the standard site for routine peripheral pulse assessment in an awake adult. It is located on the thumb side of the wrist and is generally easy to access without unnecessarily exposing the patient or requiring an awkward position. For this reason, medical assistants commonly use the radial pulse when obtaining routine vital signs. The examiner places the pads of the index and middle fingers lightly over the artery, then assesses the pulse rate and, as appropriate, its rhythm and strength. The thumb should not be used because the examiner may perceive their own thumb pulse and obtain an inaccurate result. A radial pulse may be counted for 30 seconds and multiplied by two when rhythm is regular; if rhythm is irregular, it should be counted for a full 60 seconds. The American Heart Association identifies the radial pulse as a common location for pulse assessment, and MedlinePlus describes checking the pulse at the wrist on the thumb side. See American Heart Association: All About Heart Rate (Pulse) and MedlinePlus: Pulse.