Medical Terminology

Self-study course

Course objectives

At the end of this course you will be able to:

1) Identify three benefits of knowing medical terminology

2) Identify five medical words, terms or symbols used in documentation

3) Identify five medical words, terms or symbols that might be used in an order

Medical terminology

You probably think medical terms are long unpronounceable words that only doctors and nurses can understand. This is not true! People use medical terms every day. We commonly used medical terms such as: flu, pneumonia, cancer, and cardiac disease. With a little bit of practice you too can understand the world of medical terminology.

The words, terms or symbols that make up the language of medicine are referred to as medical terminology. Like every other language, medical terminology has changed over time, but the majority of terms are based in Latin or Greek.

Most terms can be broken down into one or more word parts. In medical terminology there are three possible word parts. Any given medical term may contain one, some or all of these parts. The three parts are:

1) prefixes
2) roots
3) suffixes

Prefixes

A prefix is a word segment placed at the beginning of a word. A prefix helps to change or define the meaning of the word. Prefixes are always combined with other word segments. They are never used alone. Here are a few examples of common prefixes and what they mean.

anti — against
brady — slow
hemi — half
hypo — below/deficient
poly — many
semi — half
tachy — fast/rapid
dys — difficult/labored/painful
hyper — above/excessive
mal — bad

Roots

The root of a word contains its basic meaning. It is combined with another root, with prefixes and with suffixes in various combinations to form a medical term.

A vowel is added when two roots are combined or when a suffix is added to a root. The vowel is called a combining vowel and is usually an "o." An "i" is sometimes used when there is no vowel between the two combined roots or between the root and the suffix. A combining vowel makes pronunciation easier. Here are a few examples of common roots and what they mean.

bronch — bronchus

cardi — heart

gastr — stomach

glycos — sugar

nephr — kidney

pseudo — false/fake

therm — heat

thromb — clot

thyroid — thyroid gland

urin — urine/urinary tract

Suffixes

A suffix is placed at the end of a root to also change or help define the meaning of the word. Suffixes are not used alone. Like prefixes and roots they are from Greek or Latin. Here are a few examples of suffixes and what they mean:

ectomy — excision or surgical removal

emia — blood condition

ism — state of

itis — inflammation of

ology — study of

ostomy — creating of an artificial opening

plegia — paralysis

pnea — breathing

thorax — chest

Making words

Medical terms are formed by combining word segments. A root can be combined with prefixes, roots or suffixes. For example, the prefix dys (difficult) can be combined with the root pnea (breathing). This forms the term dyspnea meaning difficulty in breathing.

Roots can be combined with suffixes. The root mast (breast) combined with the suffix ectomy (excision or removal) forms the term mastectomy. It means removal of a breast. Combining a prefix, root, and suffix is another way to form medical terms. Endocarditis consists of the prefix endo (inner), the root card (heart), and the suffix itis (inflammation). Endocarditis means inflammation of the inner part of the heart.

The important things to remember are that prefixes always come before roots and suffixes always come after roots. Some people find it easier to begin with the suffixes when translating medical terms. For example, itis means inflammation so just by looking at the word we know we are talking about an inflammation somewhere.

Why learn medical terminology?

During the course of our day to day work we come across many words, terms and symbols. These words, terms and symbols make up what is called medical terminology. Today's medical terms have their basis in either Latin or Greek so not all of the terms/words will make sense. For example, NPO stands for Nil Per Os or nothing by mouth.

As a member of the health care team you need to know what these words, terms and symbols mean. You will see them written in diagnoses, medication orders and you will use them as part of your every day documentation.

The benefits of learning medical terminology include:

1) being able to communicate better with other health care team members,
2) being able to carry out orders and instructions correctly
3) improving the quality of your documentation

Let's now discuss these three distinct areas. Some of the medical terms may be used in more than one area.

Communicating with the health care team

When communication occurs with other health care team members, medical terms are used on a regular basis to convey a lot of information without having to use a lot of words. For example, the acronym COPD stands for Chronic Obstructive Pulmonary Disease. As you can see it is easier to say "the patient has COPD" then to say "the patient has chronic obstructive pulmonary disease." You are communicating the same information but in a lot less time.

The following is a list of common medical terms used when communicating verbally with members of the health care team. This is not an all-inclusive list — just a listing of some common terms.

A Fib — atrial fibrillation

AMA — against medical advice

ASHD — arteriosclerotic heart disease

BM — bowel movement

BP — blood pressure

CAD — coronary artery disease

CBC — complete blood count

CHF — congestive heart failure

CNS — central nervous system

COPD — chronic obstructive pulmonary disease

CP — cerebral palsy

CPR — cardiopulmonary resuscitation

CVA — cerebrovascular accident

D/C — discontinue

DD — developmentally delayed

DKA — diabetic ketoacidosis

DNR — do not resuscitate

DOB — date of birth

ECG/EKG — electrocardiogram

ER — emergency room

GI — gastrointestinal

H& P — history and physical

HMO — health maintenance organization

IM — intramuscular

IV — intravenous

LOC — level of consciousness

MD — medical doctor

MI — myocardial infarction

MR — mental retardation

MS — multiple sclerosis

NGT — nasogastric tube

NPO — Nil Per Os (nothing by mouth)

O2 — oxygen

OD — overdose

OT — occupational therapy

PCP — primary care physician

PE — pulmonary edema

PEG — percutaneous endoscopic gastrostomy (gastric tube) (GI tube)

PT — physical therapy

RBC — red blood cell

Rx — prescription

SOB — shortness of breath

TB — tuberculosis

TIA — transient ischemic attack

TPN — total parental nutrition

TPR — temperature, pulse, respiration

URI — upper respiratory infection

UTI — urinary tract infection

Practice

You are a care provider considering whether to accept the following resident. The person making the inquiry is stating the resident has the following diagnoses; A fib, ASHD, CHF and COPD. The H&P does not indicate any behavior problems. The patient does have a DNR order. They will be admitted from the ER with an NGT. The MD will be looking to see if the person has a possible UTI.

Define the following words:

AMA

H&P

ASHD

DNR

CHF

NGT

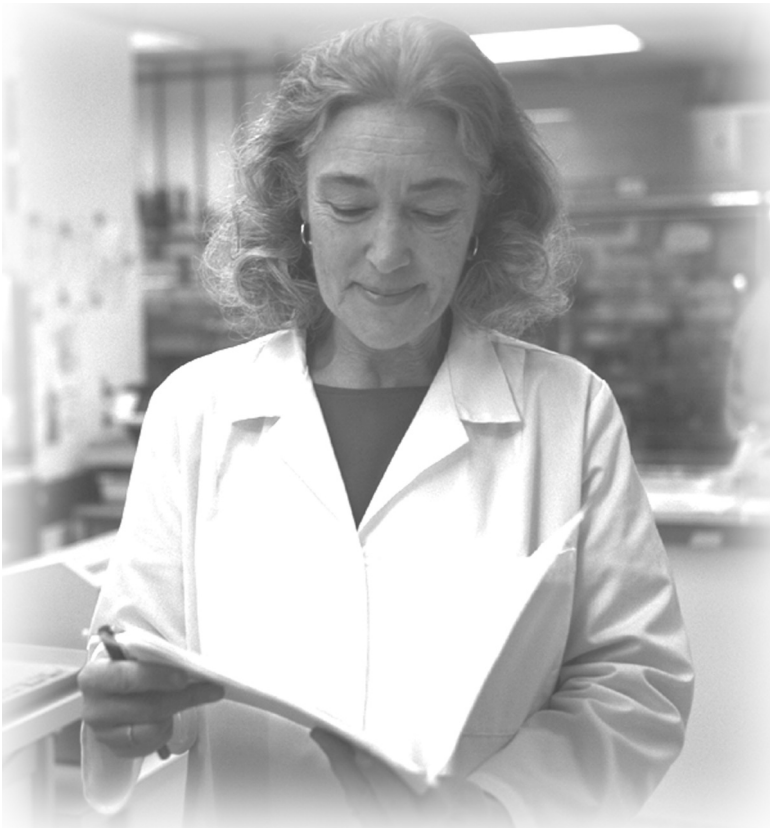
COPD

UTI

Medical orders

Another place where we see different medical words, terms and symbols is in medical orders. These orders can range from how and when a medication is to be given to how often an ordered treatment is to be performed.

It is especially important that we understand what these medical words, terms and symbols mean because not following orders could have negative consequences for the people in our care. This is not an all inclusive list.



ac — before meals

AMA — against medical advice

am — morning

amt — amount

ASA — acetylsalicylic acid (aspirin)

BID — Bis In Die (twice a day)

BM — bowel movement

BP — blood pressure

BS — bowel sounds

c — with

caps — capsules

cc — cubic centimeter

CP — chest pain

D/C — discharge

DC — discontinue

DNR — do not resuscitate

Dx — diagnosis

F/U — follow up

FBS — fasting blood sugar

Fx — fracture

FYI — for your information

gtts — drops

H&P — history and physical

hr — hour

HTN — hypertension

Hx — history

I&O — intake and output

IM — intramuscular

IV — intravenous

liq — liquid

LPM — liters per minute

meds — medications

mid noc — midnight

min — minute

ml — milliliter

mEq — milliequivalent

MD — medical doctor

noc — night

NPO — Nil Per Os (nothing by mouth)

NSAID — non-steriodal antiinflammatory drug

NTG — nitroglycerin

N/V — nausea/vomiting

NC — nasal cannula

NGT — nasogastric tube

NKDA — no known drug allergies

OTC — over the counter

O2 — oxygen

oz — ounce

pc — after meals

per — by/through

pm — afternoon

PCN — penicillin

PEG — percutaneous endoscopic gastrostomy (gastric tube)

PO — Per Os (by mouth)

PRN — Pro Re Nata (as necessary)

pt — patient

PT — physical therapy

Q — every

QD — each day

QH — every hour

Q2H — every two hours

Q3H — every three hours

QHS — every night at bedtime

QID — Quarter In Die (4 times a day)

QOD — every other day

Rx — prescription

s — without

SOB — shortness of breath

stat — immediately

SQ — subcutaneous

tabs — tablets

Continued on page 10

TB — tuberculosis

tbsp — tablespoon

tsp — teaspoon

TIA — transient ischemic attack

TID — three times a day

TX — treatment

UA — urine analysis

URI — upper respiratory infection

UTI — urinary tract infection

VS — vital signs

w/ — with

w/o — without

w/c — wheelchair

wt — weight

x — times

Practice

Translate the following orders:

Ambien one tab po QHS

Zantac one tab BID

Reglan 1 tab ac TID

NPO after mid noc

Tylenol 2 tabs Q4hrs PRN

DC previous orders

Documentation

Documentation is one of the most important tasks a caregiver will complete on a regular basis. It is in your documentation where you show what care and services were given, what the person's response to those care and services were, progress or lack of progress, assessment of problems, evaluations of goals, teaching etc.

Documentation is a form of communication when other members of the health care team visit to review a person's progress. Because documentation is so vital, it is important that your documentation be accurate, objective and concise. The use of standardized medical words, terms and symbols will help you convey what has been happening in the least amount of words.

There are going to be times when you may need to be more descriptive than the following words, terms and symbols. Medical terminology should never be used as a substitute for complete documentation. Your documentation should include whatever words, terms, or symbols are needed to ensure your documentation is complete and accurate.

A/O — alert and oriented

ADL — activities of daily living

ac — before meals

ad lib — as desired

AM — morning

AMT — amount

AMA — against medical advice

ASA — acetylsalicylic acid (aspirin)

ASHD — arteriosclerotic heart disease

BID — Bis In Die (twice a day)

BM — bowel movement

BP — blood pressure

BS — bowel sounds

c — with

DC — discontinue

CA — cancer

CAD — coronary artery disease

CBC — complete blood count

CHF — congestive heart failure

CNS — central nervous system

c/o — complains of

COPD — chronic obstructive pulmonary disease

CP — cerebral palsy

CP — chest pain

CPR — cardiopulmonary resuscitation

CVA — cerebrovascular accident (stroke)

CXR — chest x-ray

Continued on page 12

DNR — do not resuscitate

DOB — date of birth

DR — doctor

drsg — dressing

Dx — diagnosis

ECG — electrocardiogram

ER — emergency room

ETOH — alcohol

FBS — fasting blood sugar

F/U — follow up

Fx — fracture

GI — gastrointestinal

H&P — history and physical

hr — hour

HS — hour of sleep

HTN — hypertension

Hx — history

I&O — intake and output

IM — intramuscular

IV — intravenous

lab — laboratory

LOC — level of consciousness

LTC — long-term care

meds — medications

mid noc — midnight

min — minute

MD — medical doctor

MI — myocardial infarction

MR — mental retardation

mos — month

neg — negative

noc — night

N/V — nausea/vomiting

NGT — nasogastric tube

NKDA — no known drug allergies

NPO — Nil Per Os (nothing by mouth)

NTG — nitroglycerin

O2 — oxygen

OT — occupational therapy

pc — after meals

per — by/through

PEG — percutaneous endoscopic gastrostomy (gastric tube)

pm — afternoon

PO — Per Os (by mouth)

POLST — physician's orders for life sustaining treatment

PRN — Pro Re Nata (as necessary)

PT — physical therapy

pt — patient

Q — every

QD — each day

QH — every hour

Q2H — every 2 hours

Q3H — every 3 hours

QID — Quarter In Die (4 times a day)

QHS — every night at bedtime

QOD — every other day

ROM — range of motion

Rx — prescription

s — without

S/S — signs and symptoms

SOB — shortness of breath

stat — immediately

Sx — symptoms

tbsp — tablespoon

TB — tuberculosis

TIA — transient ischemic attack

TID — three times a day

TPN — total parenteral nutrition

TPR — temperature, pulse, respiration

tsp — teaspoon

TX — treatment

U/A — urinary analysis

URI — upper respiratory infection

UTI — urinary tract infection

VS — vital signs

W/ — with

W/O — without

W/C — wheelchair

WNL — within normal limits

WT — weight

X — times

Y/O — year old

Practice

Translate the following entry:

James W. is a 26 y/o A/O male with a Dx of CP who was admitted to room 3a from the ER at Valley Hospital. He will be here short term for a F/U with PT for a Fx of his rt leg. His past medical Hx is clear for any other major illnesses except for those associated with his CP. He has NKDA. So far has adjusted well to the facility and c/o not having younger males around to talk to. Is up and about ad lib. Up in w/c daily. VS stable. Helen Helpful

Final note

Medical terminology is a useful tool to communicate with other members of the health care team. It is not a substitute for good communication. It is a tool to aid you only. As a caregiver, it is your responsibility to always clarify any orders or documentation you do not understand.

Answers to practice questions

Page 7 —

AMA = against medical advice

ASHD = arteriosclerotic heart disease

CHF = congestive heart failure

COPD = chronic obstructive pulmonary disease

H & P = history and physical

DNR = do not resuscitate

NGT = nasogastric tube

UTI = urinary tract infection

Page 10 —

Ambien one tablet by mouth at bedtime

Zantac one tablet twice a day

Reglan one tablet before meals three times a day

nothing by mouth after midnight

Tylenol 2 tablets every 4 hours as requested

Discontinue previous orders

Page 13 —

James W. is a 26 year old alert and oriented male with a diagnosis of cerebral palsy who was admitted to Room 3a from the emergency room at Valley H ospital He will be here short term for a follow up with physical therapy for a fracture of his right leg. His past medical history is clear for any other major illnesses except for

those associated with his cerebral palsy. He has no known drug allergies. So far has adjusted well to the facility and complains of not having younger males around to talk to. Is up and about as he desires. Up in wheelchair daily. Vital signs stable.

Helen Helpful

This publication is available in
alternate formats.
Call 1-800-282-8096 V/TTY

Oregon Department of
Human Services
Seniors and People with
Disabilities
500 Summer St. NE, E13
Salem, Oregon 97301-1073

Phone: 1-800-232-3020 V/TTY
V/TTY: 503-945-5811
Fax: 503-378-8966

DHS
Oregon Department
of Human Services