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 suffixectomy (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-steroidal 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

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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

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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)
PQST — 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

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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

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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

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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 Hospital. 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
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