尤培成編著

實用醫學英語手冊

A Handbook of Medical English

大光出版社有限公司
世界圖書出版公司

實用醫學英語手册

A Handbook of Medical English

尤培成編著

大光出版社有限公司
世界图书出版公司

实用医学英语手册

尤培成　编著

大光出版社有限公司出版

世界图书出版公司　重印

（北京朝内大街 137 号）

北京中西印刷厂印刷

新华书店北京发行所发行　各地新华书店经售

1991年 2 月第 1 版　开本：787 × 1092 1/32

1991年 2 月第 1 次印刷　　印张：9.125

印数：0,001—1,550　字数：20.6万字

ISBN 7-5062-0828-8/R· 17

定价：4.50元

TABLE OF CONTENTS
目 錄

出版說明

本手冊是爲需要學習醫學英語的醫生和其他醫務工作者而編譯的。範圍廣泛，包括如何寫英文病歷，各系統物理檢查記錄，臨床病歷摘要及治療過程記錄，各種化驗、X綫、及心電圖報告，英、美兩國常用的醫學名詞縮寫，醫學名詞基本結構知識如前綴、後綴 、 連字符號及複數等。本手冊並附錄各種醫院常用表格，諸如入院、出院證明書，各種體格檢查表，各種化驗申請單、報告表等。附錄中並列有外科常用各種敷料名稱，器械名稱，手術及治療名稱，以及公制與英制重量、衡量單位名稱及其換算。

本手冊內容實用，查閱方便。不但可供學習醫學英語，也可供醫生及一般醫務工作者做案頭備攷，隨時查閱。

書中所有英文材料均取自最新的英文醫學書籍，都是當前流行實用的。本手冊英中對照，既有助於學習，也便於查對。編譯者本身是一位在國內受過正式訓練的醫師，譯文比較準確，所譯的中文名詞術語，均採用國內當前醫學教科書及文獻通用名詞，因此較爲正規。

PART I—HISTORY OF ILLESS

The first part of the doctor's record of a patient is the history. This consist of information gathered from the patient, or an informant prior to the present examination (if the patient is unable to communicate due to illness or language barrier, concerning his history).

The following is a basic outline for a history:

A. CHIEF COMPLAINT
B. PRESENT ILLNESS
C. PAST HISTORY
D. FAMILY HISTORY
E. SOCIAL HISTORY
F. REVIEW OF SYSTEMS

Sometimes doctors will find little use for such a complete record in their office files, as many of the aspects of the history will be completely negative. In such condition, it may be allowed to combine two or more into a single paragraph, or you may state "not pertinent" or "noncontributory".

STATISTICAL DATA (GENERAL DATA)

Before the doctor begins to take the history from

第一章　病　史

醫生對病人的記錄第一部份是病史，這包括從患者或是病情陳述者（當患者因病或語言障碍不能被詢問病史及敘述病情時）那裏，在沒有進行檢查之前所搜集到的。以下是病史的基本綱要：

A．主訴
B．現病史
C．過去史
D．家族史
E．社會生活史
F．系統複習（系統回顧）

如此完整的記錄有時醫生會發現到保存在病案夾裏價值不大，因爲在某些情況下，病史的許多方面可以完全是陰性（無主要內容），在此種情況下，便允許把幾項合併或者註明「無可記述」或「無關緊要」。

統計資料　（一般項目）

一個醫生在向患者詢問病史前他首先要知道患者的一些

the patient he will want to know certain things about the patient such as his age, sex, colour, religion and date of birth. These will be necessary for the records, and some doctors may desire the names of parents of immediate family, the place of birth, and other information. It is always advisable to have the names of the nearest relatives in case of an emergency which might require the signing of an "operative permit" or some other legal document by someone other than the patient himself.

Aside from identification purposes, the statistical information on a patient is quite pertinent in that many illnesses occur principally in patients of a particular sex, age group, race or religious group.

This statistical information can appear on the history sheet in several different ways: as a heading, as the first paragraph of the history, or as an integral part of the chief complaint. If the patient is seen in the doctor's office, the complete record would usually be a type of form filled out by the patient himself on his first visit to the doctor. In the hospital, this information is usually contained on an admission card, again filled out by the patient, in the admissions office before the patient is seen by the doctor.

情況，例如他的年齡，性別，種族，宗教信仰及出生年月，這些對病史是很重要的。在某些情況下醫生甚至還需問及患者父母的姓名，近親以及其出生地點等。對於急症病人，其近親姓名尤爲重要，因爲他們可能會被要求簽署「同意手術書」或其他與法律有關的文件。

統計資料除了作爲患者身份證明外，尙與疾病的診斷有關，因爲很多疾病往往發生於一定性別，一定年齡，一定種族或宗教信仰。

統計資料在病歷單上可以幾個不同形式出現。如作爲標題，作爲病史第一段，或作爲主訴不可分隔的組成部份。如果患者是在醫生診所看病，這一項記錄通常是由患者在首次見醫生時自己在已經印好的表上填寫，如果是在醫院，通常已包括在入院卡裏，由患者在入院處填寫好。

SAMPLES OF STATISTICAL DATA

AS A HEADING:

NAME: Jane Andrew FATHER: Houston
SEX: Female RACE: Caucasian
AGE: 18 RELIGION: R.C.
DATE OF BIRTH: 12-6-1957

or:
JANE ANDREW
18 years, Female
D.O.B. 12-6-1957
Caucasian

AS THE FIRST SENTENCE:

The patient is an eighteen year-old white female.....

or:
Jane Andrew, an 18 year-old caucasian female, born 12-6-1957 .....

INCORPORATED INTO THE CHIEF COMPLAINT:

The patient was an eighteen year-old caucasian female, first seen in the office with a chief complaint of upper respiratory infection of 3 days' duration. The patient was born on the 12th of June, 1957 in County General Hospital.....

統計資料實例

作爲標題

姓名：珍妮·安德魯　父親：豪斯頓
性別：女性　種族：白種人
年齡：18歲　信仰：羅馬天主教
出生日期：1957年6月12日

或

珍妮·安德魯
18歲，女性
出生日期：1957年6月12日
白種人

作爲病史頭一段

患者是一個十八歲白種人女性……

或

珍妮·安德魯，一個18歲白種女性，57年6月12日生……

併入主訴內

患者是一個18歲白種女性，首次就診主訴爲三天上呼吸道感染。患者在1957年6月12日生於州立總醫院。

CHIEF COMPLAINT

The chief complaint is usually one or two brief sentences, occasionally in the patient's own words (and therefore sometimes very picturesque). This contains tangibles and intangibles as well, i.e. the patient may notice any alteration or deviation from norm in his mental status, such as depression or agitation, or in his bodily functions, such as any blood in the sputum (hemoptysis), vomitus (hematemesis) or bowel movement (melena), and the duration of this. The chief complaint is, in essence, the reason that the patient is seeking the advice of a physician. He may note any difficulty in breathing, walking, any dizziness or fainting spell. At times the chief complaint is not even specific and the patient may only tell of a general feeling of not being well, called malaise.

SAMPLES OF CHIEF COMPLAINT

1. CHIEF COMPLAINT: The patient is a 56 year-old male admitted with the chief complaint of black tarry stools of three days' duration.
2. CHIEF COMPLAINT: The patient was seen in the office for the first time with "shaking chills and a feeling of falling down" associated with blurred vision and difficulty in breathing of one day's duration.

主　　訴

主訴通常是一兩句簡單的句子，有時可用患者自己的話來記述（有時是很形象化），這包括有形的或無形的，即如患者可能注意到其精神狀態有所改變或不正常，例如抑鬱或激越；或身體功能上發現異常，如痰裏有血（咯血），嘔吐物裏有血（嘔血），或大腸排洩物裏有血（便血），以及其持續時間。從實質上來說主訴就是患者就診尋醫的主要原因。它可以是患者所感到的呼吸或行走困難，眩暈眼花。有時病人的主訴不是很具體，甚至病人只會告訴你他感到周身不適而已。

主訴實例

例一：主訴：患者是一個56歲男性，入院主訴是三天柏油樣便。

例二：主訴：患者是因「寒戰，衰竭感」並伴有視力模糊及呼吸困難一天而首次就診。

3. CHIEF COMPLAINT: The patient is a 47 year-old male who was a heavy smoker and a heavy drinker, and who was admitted with a chief complaint of marked dyspnea, orthopnea and cough which was productive of yellow and greenish sputum for the past three to four days. The patient stated that he had a history of chronic bronchitis and a mild cold one week prior to this admission.
4. CHIEF COMPLAINT: The patient was an obese 46 year-old male who came to the office with a chief complaint of a two-day history of severe abdominal pain, colicky in nature, associated with vomiting. The patient stated that the vomiting had increased and had become bright red in colour, with severe abdominal pain.
5. CHIEF COMPLAINT: Amputated 2nd toe and lacerated wound of the third toe, left, with extensive damage to tissue and tendon.
6. CHIEF COMPLAINT: The patient came to the office with a complaint of bloody diarrhea and abdominal pains. In addition, the patient complained of being very tired and weak, and having had no appetite for several days prior to this.
7. CHIEF COMPLAINT: The patient was seen in the office with a chief complaint of wheezing respirations of 24 hours' duration.

PRESENT ILLNESS

The present illness is a record of the present complaint