# UNIVERSITY OF WASHINGTON MEDICAL CENTER – RADIOLOGY
## Bone Density Questionnaire
华大医疗中心—放射科
骨密度测试问卷

Chinese

**Name** 姓名_____ **Birthday** 生日 ____/____/_____

**Current Height** 目前身高_____ **Current Weight** 目前体重_____ **lbs.**

**What is your ethnic group?  WHITE / BLACK / HISPANIC / ASIAN / OTHER** (circle one)
您属什么种族？**白人/黑人/西班牙族/亚裔/其他**（请圈选一项）

☐ **Yes** 是 ☐ **No** 否      **Are you pregnant?**
您是否怀孕？

☐ **Yes** 是 ☐ **No** 否      **Is there metal in your Lumbar Spine** (lower back)**?**
您的腰椎有无任何金属（腰部）？

☐ **Yes** 是 ☐ **No** 否      **Is there metal in either Hip?**
您的髋关节有无任何金属？

☐ **Yes** 是 ☐ **No** 否      **Do you have Hyperparathyroidism?**
您副甲状腺功能亢进吗？

☐ **Yes** 是 ☐ **No** 否      **Have you had a barium study in the past 10 days?**
您在过去的 10 天中做过钡剂测试吗？

☐ **Yes** 是 ☐ **No** 否      **On average, do you consume more than 2 alcoholic beverages per day?** (12 oz. beer, 5 oz. wine, 1.5 oz. spirits)
您每天平均喝 **2** 杯以上的酒吗？（12 盎司啤酒、5 盎司葡萄酒、1.5 盎司烈酒）

☐ **Yes** 是 ☐ **No** 否      **Does your mother or father have a history of hip fracture?**
您的父母亲曾经有过髋骨折吗？

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☐ **Yes** 是 ☐ **No** 否      **Have you taken oral Prednisone, or other glucocorticoids, for more than 3 months at a dose of 5mg or more daily?**
您是否每天口服强的松或其他糖皮质激素超过 3 个月，剂量为 5mg 或更多？

☐ **Yes** 是 ☐ **No** 否      **Do you have a history of fracture in your adult life?** (Do not count bones in the head, neck, hands, feet, or knee cap, or fractures from car accidents or other high impact traumas)
您成年后有无骨折过？（头骨、颈椎、手、脚、或膝盖、或因车祸、及其他的高撞击导致的骨折排除）

☐ **Yes** 是 ☐ **No** 否      **Do you have a confirmed diagnosis of Rheumatoid Arthritis?**
您是否被确诊为有类风湿性关节炎？

☐ **Yes** 是 ☐ **No** 否      **Do you currently smoke tobacco?**
您目前抽烟吗？

**Chinese Translation by UWMC Interpreter Services**

PLACE PATIENT LABEL HERE

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