UCSF Medical Center
Endometriosis Center

Name: _____

Date: _____

New Patient Intake Form

Welcome to the UCSF Endometriosis Center! Please help us by filling out the following form to the best of your ability.

Who referred you to our Center? _____

What is the reason for your visit today? _____

***Pain:* Please help us understand your pain more thoroughly.**

What is the nature of your pain? (dull, achey, sharp, tearing, etc.) _____
Where is your pain located? _____
How long does your pain last? _____
How would you describe your pain? (Check one) → ☐Constant ☐Intermittent ☐Other, Specify: _____
Does your pain come at a certain time in your cycle? ☐Yes ☐No
Does your pain radiate? ☐Yes ☐No
If yes, please elaborate : _____
On a scale of 1-10, 10 being the worst, how would you rate your pain? (Circle) 0 1 2 3 4 5 6 7 8 9 10
What factors exacerbate your pain? _____
What alleviates your pain? _____
How often do you miss school or work because of this pain _____

How often do you have a bowel movement? _____
Do you experience any of the following bowel symptoms? (Check all that apply)
☐ Constipation ☐ Diarrhea ☐ Pain with bowel movements ☐ Blood in your stool
Do you experience any of the following urinary symptoms? (Check all that apply)
☐Pain with urinating ☐ Urinary frequency ☐ Urgency ☐ Blood in urine ☐Pain with bladder fullness

Have you had fevers, chills, or night sweats?	☐Yes	☐ No	
Do you experience pain with sexual intercourse?	☐Yes	☐ No	☐ Not sexually active
Have you had abnormal vaginal discharge?	☐Yes	☐ No	

Menstrual Cycle
What was the ***first*** day of your last menstrual period: _____
How long does your period last? _____
Does your menses come once a month around the same time each month? _____

Do you experience bleeding between periods?	☐Yes	☐ No	☐ Not sure
Do you desire future fertility?	☐Yes	☐ No	☐ Not sure

Imaging & Prior Procedures

Have you ever had a pelvic ultrasound?	☐Yes	☐ No	Date(s): _____
Have you ever had a pelvic MRI?	☐Yes	☐ No	Date(s): _____
Have you ever had a CT of your abdomen or pelvis?	☐Yes	☐ No	Date(s): _____
Have you ever had a colonoscopy?	☐Yes	☐ No	Date(s): _____
Have you ever had a endoscopy?	☐Yes	☐ No	Date(s): _____

PLEASE TURN OVER PAGE →

***Surgical History**:*
Please list all prior abdominal or pelvic surgical procedures you have had. If more than 4 please use backside of sheet

Procedure	Date	Surgeon	Location	Outcome
1)				
2)				
3)				
4)				

Prior Treatment: Which of the following treatments have your previously pursued? Check all that apply.

☐Acupuncture
☐Family Practitioner
☐Nutrition / diet
☐Anesthesiologist
☐Herbal Medicine
☐Physical Therapy
☐Anti-seizure medications
☐Homeopathic medicine
☐Psychotherapy
☐Neurosurgeon
☐Nonprescription medicine
☐Antidepressants
☐Lupron, Synarel, or Zoladex
☐Psychiatrist
☐Biofeedback
☐Massage
☐Rheumatologist
☐Botox injection
☐Meditation
☐ Skin magnets
☐Urologist
☐Other _____
☐Oral contraceptive / patch / ring
☐Narcotics
☐Surgery
☐Danazol (Danocrine)
☐TENS unit
☐Depo-provera
☐Nerve blocks
☐Trigger point injections
☐Gastroenterologist
☐Gynecologist
☐Reproductive Endocrinologist/ Infertility Specialist

Do you have any questions for your provider?

_____
_____
_____
_____

Thank you so much!