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 an 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 you previously pursued? Check all that apply.*

Specialist:
☐ Physical Therapist
☐ Rheumatologist
☐ Gynecologist
☐ Gastroenterologist
☐ Fertility Specialist
☐ Anesthesiologist
☐ Psychiatrist
☐ Urologist
☐ Osteopath
☐ Therapist

Medication(s):
☐ Lupron, Synarel, or Zoladex
☐ Depo-provera
☐ Narcotics
☐ Oral contraceptive / patch / ring
☐ Antidepressants
☐ Danazol (Danocrine)
☐ Vitamins/Supplements
☐ NSAIDs (i.e ibuprofen)

Alternative/Other
☐ Nutrition / diet
☐ Biofeedback
☐ Massage
☐ Herbal Medicine
☐ Acupuncture
☐ Ayurveda
☐ Guided Imagery
☐ Cannabis / CBD / THC
☐ Yoga
☐ Physical Exercise
☐ Homeopathic medicine
☐ TENS unit
☐ Meditation

Medical Intervention:
☐ Surgery/Laparoscopy
☐ Skin magnets
☐ Botox injection
☐ Trigger point injections
☐ Nerve blocks

☐ Other(s) _____
_____
_____

What questions do you have for your provider?
_____
_____
_____
_____

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feeling that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
I worry all the time about whether the pain will end	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
I feel I can't go on	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
It's terrible and I think it's never going to get any better	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
It's awful and I feel that it overwhelms me	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
I feel I can't stand it anymore	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
I become afraid that the pain will get worse	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
I keep thinking of other painful events	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
I anxiously want the pain to go away	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
I can't seem to keep it out of my mind	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
I keep thinking about how much it hurts	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
I keep thinking about how badly I want the pain to stop	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
There's nothing I can do to reduce the intensity of the pain	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
I wonder whether something serious may happen	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

Made accessible
4/23