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 <u>abdominal or pelvic</u> 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?

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Thank you so much!