VIKING MEDICAL GROUP
Specialized Care for Men & Women

Original Date:
Dates Revised:

VIKING MEDICAL GROUP PATIENT INTAKE FORM

Please fill in all information as accurately as possible, as this information is used to formulate a Personalized Health Plan. All answers are confidential.

Name *(Last, First, M.I.):*		**DOB:**	
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Email:		**Phone Number:**	
Address:		**Emergency Contact:**	
PCP or Referring Provider:		**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

List your prescribed and over-the-counter medications

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

Past Medical History

Year	Diagnosis	Ongoing Issue?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Surgeries

Year	Reason	Hospital

HEALTH HABITS						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (Climbing stairs, walking 3 blocks, golf)					
	☐ Occasional vigorous exercise (Less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Soda		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – #/day _____		☐ Chew - #/day _____	☐ Pipe - #/day _____	☐ Cigars - #/day ____	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
Sexual Health	Are you sexually active?				☐ Yes	☐ No
	Have you had/have issues achieving or maintaining an erection?				☐ Yes	☐ No
	Date of last prostate and rectal exam?					
	Any discomfort with intercourse?				☐ Yes	☐ No
	Any testicular pain or swelling?				☐ Yes	☐ No
	Do you usually get up to urinate during the night?				☐ Yes	☐ No
	If yes, # of times _____					
	Do you feel pain or burning with urination?				☐ Yes	☐ No
	Any blood in your urine?				☐ Yes	☐ No
	Do you feel burning discharge from penis?				☐ Yes	☐ No
	Has the force of your urination decreased?				☐ Yes	☐ No
	Have you had any kidney, bladder, or prostate infections within the last 12 months?				☐ Yes	☐ No
	Do you have any problems emptying your bladder completely?				☐ Yes	☐ No

MENTAL HEALTH		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No

OTHER CONCERNS		
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.		
☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

FAMILY HEALTH HISTORY					
	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		