WELLNESS BY EMCURA

4050 W Maple Road, STE 101
Bloomfield Twp, MI 48301

Advanced Cardiac Assessment Intake

Patient Name: _____ Date of Birth: _____

Section 1: Medical History

Have you ever been diagnosed with any of the following? (Check all that apply)

- [ ] High blood pressure
- [ ] High cholesterol
- [ ] Coronary artery disease
- [ ] Arrhythmia or irregular heartbeat
- [ ] Congestive heart failure
- [ ] Heart murmur
- [ ] Stroke or TIA (mini-stroke)
- [ ] Peripheral artery disease
- [ ] Diabetes or prediabetes
- [ ] Sleep apnea
- [ ] Cancer (type: _____)
- [ ] Bleeding disorder (e.g., hemophilia, von Willebrand disease)
- [ ] Clotting disorder (e.g., Factor V Leiden, history of DVT/PE)
- [ ] Other: _____

Has any family member been diagnosed with a bleeding or clotting disorder?

[ ] Yes [ ] No If yes, please describe: _____

Have you ever been on hormone therapy?

[ ] Yes [ ] No If yes, please describe: _____

Have you ever seen a cardiologist?

[ ] Yes [ ] No If yes: Name: _____Facility: _____

Approx. date of last visit: _____Reason for visit/diagnosis: ___

Section 2: Symptoms

Do you currently experience, or have you recently experienced any of the following? (Check all that apply)

- [ ] Chest pain or pressure
- [ ] Shortness of breath (with activity or at rest)
- [ ] Palpitations or fluttering sensation
- [ ] Dizziness or fainting
- [ ] Swelling in legs or ankles
- [ ] Fatigue or reduced exercise tolerance
- [ ] Persistent cough (especially at night)
- [ ] Numbness or pain in arms or legs

Section 3: Medication & Supplement Use

1. Current prescription medications:

_____

2. Over-the-counter medications used regularly:

_____

3. Vitamins or dietary supplements used regularly:

_____

4. Have you discontinued any medications or supplements recently? [ ] Yes [ ] No

If yes, please explain: _____

Section 4: Family History

For each condition, indicate Yes/No, affected family member(s), and age at diagnosis (if known):

[ ] Heart attack (myocardial infarction) - Family Member(s): _____ Age at Diagnosis:_____

[ ] Stroke or TIA - Family Member(s): _____ Age at Diagnosis: _____

[ ] High blood pressure - Family Member(s): _____ Age at Diagnosis: _____

[ ] High chol / lipid disorder - Family Member(s): _____ Age at Diagnosis: _____

[ ] Coronary artery disease - Family Member(s): _____ Age at Diagnosis: _____

[ ] Congestive heart failure - Family Member(s): _____ Age at Diagnosis: _____

[ ] Arrhythmias / Sudden cardiac death - Family Member(s): _____ Age at Diagnosis: _____

[ ] Diabetes (Type 1 or 2) - Family Member(s): _____ Age at Diagnosis: _____

[ ] Obesity/metabolic syndrome - Family Member(s): _____ Age at Diagnosis:_____

[ ] Sleep apnea - Family Member(s): _____ Age at Diagnosis: _____

Has anyone in your family experienced sudden or unexplained death before age 55 (men) or 65 (women)?

[ ] Yes [ ] No If yes, please describe: _____

Does your family have a known history of any of the following genetic/hereditary heart conditions?

- [ ] Hypertrophic cardiomyopathy [ ] Marfan syndrome
- [ ] Long QT syndrome [ ] Familial hypercholesterolemia
- [ ] Not sure / unknown If known, who was affected? _____

Do you have concerns about your family history and your own heart health?

[ ] Yes [ ] No If yes, please describe: _____

Section 5: Lifestyle & Risk Factors

Do you smoke or use nicotine products?

- [ ] Never [ ] Former smoker (Quit: _____) [ ] Current smoker

Alcohol use:

- [ ] None [ ] Occasionally [ ] Regularly (____ drinks/week)

Physical activity level:

- [ ] Inactive [ ] Light
- [ ] Moderate [ ] Intense

Diet pattern:

- [ ] Standard American [ ] Mediterranean [ ] Low-carb / Keto
- [ ] Plant-based [ ] Other: _____

Fruit/vegetable servings per day:

- [ ] 0–1 [ ] 2–3 [ ] 4–5+

Sleep Hours Per night? _____ Do you wake feeling rested? [ ] Yes [ ] No

Do you experience symptoms of anxiety or depression?

- [ ] Yes – Anxiety [ ] Yes – Depression [ ] No

How would you rate your current stress level (1 = very low, 10 = extremely high)?

Circle: 1 2 3 4 5 6 7 8 9 10

What are your main sources of stress? (Check all that apply)

- [ ] Work or school [ ] Financial concerns [ ] Family responsibilities / Relationships
- [ ] Health concerns [ ] Grief or trauma [ ] Unclear purpose or direction
- [ ] Other: _____

How do you manage stress? (Check all that apply)

- [ ] Exercise [ ] Meditation/mindfulness [ ] Talking with others
- [ ] Breathing techniques / Mediation [ ] None currently
- [ ] Other: _____

Section 6: Integrative Goals

What are your main concerns about your heart or circulation? What are your goals?

_____

Are you open to incorporating any of the following into your care plan? (Check all that apply)

- [ ] Nutritional counseling [ ] Herbal/supplemental therapy
- [ ] Yoga or movement therapy [ ] Acupuncture
- [ ] Stress management techniques [ ] Mindfulness or meditation
- [ ] Lifestyle coaching

I agree to discuss my treatment plan and follow-up regularly with my provider.

Signature: _____ Date: _____

Provider : _____ Date: _____