Brenda Marshall MD

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**Covid -19 Patient Intake Data & Questionnaire /Results**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: (\_\_\_)\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: (\_\_\_)\_\_\_\_\_\_\_\_\_\_

Soc Sec # (req for ordering testing): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Current Supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Onset Date of Covid-19 like symptoms? \_\_\_\_\_\_\_\_\_ Covid (+) contact? No / Yes & date\_\_\_\_\_\_.

What symptoms were present?(circle) Cough / Fever \_\_\_F / Nausea / Low appetite/Fatigue

 Diarrhea/ Body aches/ Loss of Smell / Hard to breath.

Did you have a Covid-19 nasal/oral swab? Yes / No. If so, what date? \_\_\_\_\_\_\_\_. **+** or **-** ?

Do you take Vitamin D3? Yes / no. What dose per day? \_\_\_\_\_\_ Units . With a meal? Yes / No.

Do you plan to have blood draw via(circle)- private mobile draw OR Covid Station @ Quest.

**Waiver & Consent to treat:**

I the undersigned do agree and consent to all medical treatment and services provided by Dr. Marshall and her staff. Medical Services are defined as any and all diagnostics and treatments and diagnosis provided by Dr. Marshall or her staff. This includes but is not limited to exercise programs, medicinal and alternative therapies, drug therapy, and any and all efforts to diagnose and treat any condition of myself. I further understand that the Dr. Marshall’s Consultation Service is not a walk in, or emergency services clinic and deals with specialized diagnostics and protocols. In the event that an emergency care need arises, I realize I must go to a medical facility qualified to treat such conditions I understand that any medical services provided to me by Dr. Marshall do not constitute those for life threatening situations. I agree to hold harmless and indemnify Dr. Marshall and its professionals from any and all claims involving the medical services provided by this service. I acknowledge that it is state law to provide results to Public Health Dept.

**Signature of patient (parent if minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

Office Use: Resulted Date: \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_ PHD: \_\_\_\_\_\_\_\_\_