
Client: Tahmina Islam (6133)Nov 13, 2025

1. Please note: fields with a red asterisk are mandatory.

Legal First Name: <u>Tahmina</u>	Legal Last Name: <u>Islam</u>	Date of Birth: <u>2/6/1983 (age 42)</u>	
Minor's Guardian Full Name, If Applicable: _____	Gender: <u>Female</u>	Street Address of Residence: <u>3214 Kingsbridge Ave</u>	Apt./Unit #: <u>6B</u>
City of Residence: <u>Bronx</u>	State of Residence: <u>NY</u>	Zip Code: <u>10463</u>	Mobile Phone: <u>(347) 341-9217</u>
Email: <u>bd.tahmina@yahoo.com</u>			

2. The client allows MedScape GFE to perform the good faith exam and for the good faith exam to be released to:
AcneClinicNYC

Appointment made?
No

3. Check all treatments to have now or possibly would like in the future below: *Note: MedScape GFE does not determine the treatment route and/or dosages nor prescribes. AcneClinicNYC advises on treatment options within their clinic, scope of practice and protocols according to their medical director's guidelines.

☒ Laser Facial (Nd:Yag 1064nm)	☒ Laser Facial (Nd: Yag 1064mm)	☒ Laser Facial (Alexandrite)
☒ Laser Facial (Erbuim)		☒ Laser Facial (CO2)

4. Please answer the questions below relating to the selected treatment(s) above:

Have had selected treatment(s) before? <u>Unsure</u>	Result of previous treatment(s)? <u>Steady and consistent results</u>
Goal of requested treatment(s)? Select ALL that apply. ☒ Active acne ☒ Pigmentation/brown spots ☒ Other	If needed, please explain further below: _____
Area(s) to be treated (this good faith is good for one year; therefore, approval can be for future treatments wanted): <u>Face</u>	

5. Under any type of medical care? (i.e. PCP, OB/GYN, allergist, naturopath, mental health, specialist)

No

6. For female assigned gender at birth:

Currently pregnant? ☒ No

Trying to become pregnant? ☒ No

Could possibly be pregnant? ☒ No

Currently breastfeeding? ☒ No

Going through IVF/Planning on IVF in the near future? ☒ No

7. List ALL medications below including homeopathic supplements and vitamins. If none apply, please write in "none".

	Name of Medication:	Start Date:
1	Metformin	12/15/2019
2	Cetirizine	12/15/2019

8. List ALL surgeries and hospitalizations below. This includes ALL implantation of objects placed in the body that one is not born with ie devices, stents, piercings. If none apply, please write in "none".

	Type of Surgery/Hospitalization:	Date and Year of Surgery/Hospitalization:
1	CESAREAN SECTION	12/17/2014
2	TONSILLECTOMY	05/01/2020

9. List ALL allergies below and/or dietary restrictions. If none apply, please write in "none".

	Type of Allergy:	Reaction:
1	Seasonal	Nothing

10. Vitals & Measurements

Height (ft/in or cm)

5'3"

Weight (lbs or kg)

179

Have you noticed any recent changes in your weight?

No

Do you have personal wellness or body goals you'd like us to know about?

No

If "other", please specify

11. Health History - Circulatory and Respiratory System (Please select all that apply):

☒ None of these

12. Health History - Nervous System (Please select all that apply):

☒ **None of these**

If "other", please specify

13. Health History - Digestive System (Please select all that apply):

☒ **None of these**

If "other", please specify

14. Health History - Skin (Please select all that apply):

☒ **Acne**

☒ **Melasma**

If "other", please specify

15. Health History - Mental Health & Emotional Well-Being

Do you have a history of depression, anxiety, or other mental health conditions?

No

Have you ever been hospitalized for a mental health condition?

No

If "other", please specify

If yes, are you currently receiving treatment (medication, counseling, or therapy)? N/A for none.

N/A

If yes, please specify when and which hospital. N/A for none.

N/A

16. Health History - Sexual Health & Hormones

Do you experience sexual dysfunction (low libido, erectile difficulties, vaginal dryness, or other concerns)?

No

Have you noticed changes in your energy, mood, or sleep patterns that you think may be hormone-related?

No

Would you like to have a hormonal evaluation via lab work?

No

If "other", please specify

If yes, please specify. N/A for none.

N/A

Have you ever had a hormone evaluation (testosterone, estrogen, thyroid, cortisol, etc.)?

No

17. Health History - Hair & Skin Health

Do you currently experience hair loss, thinning, or shedding?

Yes

Would you like a consultation about hair loss?

No

If "other", please specify

Have you tried any treatments for hair loss in the past?

No

Do you have a history of skin disorders (acne, eczema, psoriasis, etc.)?

Yes

18. Health History - Other (Please select all that apply):

☒ **Diabetes Type 2**

If "other", please specify

19. Please answer the lifestyle questions below:

Average stress level:

Moderate

On average, how many days per week for alcohol consumption?

None

On average, how many glasses of fluids (including water, juice, and decaffeinated tea) are consumed daily? (Glass = 8 ounces)

Around 4-8 glasses

Smoke, vape, or chew tobacco?

None

Recreational drugs?

None

Currently following any specific diet plan? If so, please specify which one(s): ☒ **Halal**

20. Approval and/or deferral to medical director's SOPs (description of treatment(s) that client is approved and/or deferred for). Please select all that apply treatments for approved and/or deferred to medical director's SOPs with AcneClinicNYC. MedScape GFE does NOT condone any off label administration or dosing of ANY treatments. We will approve, however, it is ONLY depending on if AcneClinicNYC's medical director allows for off label treatment(s). For any off label administration and dosage, AcneClinicNYC must follow policies and procedures as approved by your clinics medical director. If AcneClinicNYC's medical director does not allow for said off label treatment(s), the good faith exam note provided by MedScape GFE's and the high-level provider will be null and void.

Treatment(s) client is approved and/or denied to receive at AcneClinicNYC (select ALL that apply to visit):

☒ **Cortisone Shots** ☒ **Dermal Filler** ☒ **Neurotoxin** ☒ **Sculptra** ☒ **Laser Facial (Nd:Yag 1064nm)**
☒ **Laser Facial (CO2)** ☒ **Laser Facial (Alexandrite)**

Treatment(s) deferred to AcneClinicNYC medical director's SOPs with the reason(s) for deferral. If no explanation(s) is/are necessary, please write "not applicable":

NA

Clarification(s) needed from the client before approval. The client MUST resubmit with clarification(s) requested by the good faith exam high-level provider. If the client does not provide what the good faith exam high-level provider requests, the note is void, and therefore, the client is denied. If no explanation(s) is/are necessary, please write "not applicable":

NA

Term(s) of approved treatment(s) (select ALL that apply):

☒ 1 year (unless medical condition(s) change, medication(s) change and/or anything if anything is added to what is stated and approved in this GFE. If any of the aforementioned apply, the client must be re-seen at the time of discovery AND before their next appointment/treatment(s)

Provide treatment name(s) and explanation(s) for short-term approval(s) (under one year approval). If no explanation(s) is/are necessary, please write "not applicable":

NA

e-signature

Nov 13, 2025

Good Faith Exam completed by the following MedScape GFE Practitioner:

Danielle Trenelli, FNP-BC

Signed by Danielle Trenelli on Nov 13, 2025 at 12:49 PM from IP 71.127.239.***