Client: Kathrine Maguire (6166) Nov 13, 2025

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

Legal First Name:	Legal Last Name:	Date of Birth:
Kathrine	Maguire	8/8/1984 (age 41)

Minor's Guardian Full Name, If Applicable:	Gender:	Street Address of Residence:	Apt./Unit #:
	Female	1570 port way	

City of Residence:	State of Residence:	Zip Code:	Mobile Phone:
Oakley	CA	94561	(925) 809-0697

Email:
kathrynmaguire07@gmail.com

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

Appointment made?
At appointment now

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. Rejuvenate Aesthetics advises on treatment options within their clinic, scope of practice and protocols according to their medical director's guidelines.

- ☑ Jeuveau Neurotoxin
- ☑ NAD+ Injections
- ☑ Procell Microchanneling
- ☑ Tirzepatide
- ☑ Fillers (Evolysse and Versa)
- ☑ Glutathione Injections
- ☑ B12 Injections
- ☑ PDO Threads (PDO Max)
- ☑ MIC B12 Injections
- ☑ Semaglutide

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

Have had selected treatment(s) before?	Result of previous treatment(s)?
No	Not applicable

Goal of requested treatment(s)? Select ALL that apply.

☑ To restore volume, enhance facial contours, and soften lines or folds for a more youthful appearance
☑ To support cellular repair, improve energy levels, and enhance overall wellness and cognitive function
☑ To provide antioxidant support, promote detoxification, and help brighten and even skin tone
☑ To boost energy, support metabolism, and aid in fat breakdown for improved weight management
☑ To increase energy, support healthy nerve function, and improve overall mood and well-being

If needed, please explain further below:

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

Yes

6. "Yes" for medical care was selected. Please list the provider's name(s) and their speciality.

	Name	Speciality
1	Dr.shaked	Primary care
2	Dr.Michelle hao	On/gyn
3	Dr.yuen	Endocrinologist

7. For female assigned gender at birth:

Currently pregnant? ☑ No

Could possibly be pregnant? ☑ No

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

Trying to become pregnant? ☑ No

Currently breastfeeding? ☑ No

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

	Name of Medication and Dose:	Start Date:
1	Gabapentin	2022
2	Mesalamine	2023
3	Iron supplement	2024

9. 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/Implant and Location:	Date and Year of Surgery/Hospitalization/Implant:
1	I had pneumonia and was in the ER Walnut Creek John Muir	Oct29-nov 5th
2	Pregnancy and delivery of baby boy	2017-John Muir Hospital odd Ignacio valley road

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

	Type of Allergy:	Reaction:
1	Gluten	Intestinal inflammation
2	Wheat	Inflammation /redness of skin intestinal problems
3	Barley /Rye	Stomach upset/diharrh

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):

☑ Chronic Fatigue Syndrome ☑ Chronic Pain ☑ Fatigue

If "other", please specify
U have lupus and celiac disease

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

☑ Celiac Disease ☑ Diverticulitis ☑ Gallstones

☑ Indigestion ☑ Intestinal Gas

If "other", please specify

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

☑ Cold Sores ☑ Hives

If "other", please specify

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

☑ Anxiety ☑ Hormonal Imbalance ☑ Kidney Stones

If "other", please specify

16. Health History - Cancer

Have you ever been diagnosed with cancer?
No

If yes, please specify type, date of diagnosis, and current status (active, in remission, or treated) N/A for No.
No

Has any immediate family member (parents, siblings, children) been diagnosed with cancer?
Yes

If yes, Please specify relation, type of cancer, and age at diagnosis. N/A for No.
Breast cancer-my aunt

If "other", please specify

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

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

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

Have you ever been hospitalized for a mental health condition?
No

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

If "other", please specify

18. Health History - Sexual Health & Hormones

Do you experience sexual dysfunction (low libido, erectile difficulties, vaginal dryness, or other concerns)?
No

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

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

Have you ever had a hormone evaluation (testosterone, estrogen, thyroid, cortisol, etc.)?
No

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

If "other", please specify

19. Health History - Hair & Skin Health

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

Have you tried any treatments for hair loss in the past?
No

Would you like a consultation about hair loss?
Yes

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

If "other", please specify

20. Please answer the lifestyle questions below:

Average stress level:
High

Smoke, vape, or chew tobacco?
Trying to quit

On average, how many days per week for alcohol consumption?
Occasionally (a few times a month)

Recreational drugs?
Special occasions (a few times a year)

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

Currently following any specific diet plan? If so, please specify which one(s): ☑ Gluten-Free

21. 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 Rejuvenate Aesthetics. MedScape GFE does NOT condone any off label administration or dosing of ANY treatments. We will approve, however, it is ONLY depending on if New York Beauty Center's medical director allows for off label treatment(s). For any off label administration and dosage, New York Beauty Center must follow policies and procedures as approved by your clinics medical director. If New York Beauty Center'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 Rejuvenate Aesthetics's (select ALL that apply to visit): ☑ Jeuveau Neurotoxin ☑ Fillers (Evolysse and Versa) ☑ PDO Threads (PDO Max) ☑ NAD+ Injections ☑ Glutathione Injections ☑ MIC B12 Injections ☑ Procell Microchanneling ☑ B12 Injections

Treatment(s) deferred to Rejuvenate Aesthetics's 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 12:35 PM from IP 71.127.239.****

22. Vitals & Measurements

Height (ft/in or cm)

Five ft. 11inches

Weight (lbs or kg)

165

Have you noticed any recent changes in your weight?

Yes

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

I'd like to lose about 15-20lbs primarily in my abdomen

If "other", please specify