REJUVENATE AESTHETICS

Client: Zenaida Mccann (6170) Nov 13, 2025

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

Legal First Name: Zenaida

Legal Last Name: Mccann

Date of Birth: 01/20/1955 (age 70)

Minor's Guardian Full Name, If Applicable:

Gender: Female

Street Address of Residence: 816 donham ct

Apt./Unit #:

City of Residence: Antioch

State of Residence: CA

Zip Code: 94509

Mobile Phone: (650) 520-9878

Email: nedymccann@yahoo.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

☑ Fillers (Evolysse and Versa)

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

Have had selected treatment(s) before? Yes

Result of previous treatment(s)? Steady and consistent results

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

☑ Reducing the appearance of fine lines and wrinkles for a smoother

If needed, please explain further below:

5. "Yes" was selected for previous treatment(s). Please list treatment(s) history below. If more space is needed please add more rows by hitting the "add rows" button.

	Treatment	Last Treatment
1	Fillers	
2	Botox	

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

No

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	Losartan	01 01 2025

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	Stent	Oct 12, 2025

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

	Type of Allergy:	Reaction:
1	None	

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

☑ Asthma ☑ High Blood Pressure ☑ High Cholesterol

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):

☑ None of These

If "other", please specify

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

☑ None of these

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.
Na

Has any immediate family member (parents, siblings, children) been diagnosed with cancer?
No

If yes, Please specify relation, type of cancer, and age at diagnosis. N/A for No.
Na

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?
No

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

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

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

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.
Na

Have you noticed changes in your energy, mood, or sleep patterns that you think may be hormone-related?
No

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

Would you like to have a hormonal evaluation via lab work?
No

If "other", please specify

19. Health History - Hair & Skin Health

Do you currently experience hair loss, thinning, or shedding?
No

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

Would you like a consultation about hair loss?
No

Do you have a history of skin disorders (acne, eczema, psoriasis, etc.)?
No

If "other", please specify

20. Please answer the lifestyle questions below:

Average stress level:
Moderate

Smoke, vape, or chew tobacco?
None

On average, how many days per week for alcohol consumption?
None

Recreational drugs?
None

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): ☑ None of these ☑ Healthy

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)

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:

Sunil Kurup, MD

*Signed by MedScape GFE on Nov 13, 2025 at 05:13 PM from IP 75.251.19.****

22. Vitals & Measurements

Height (ft/in or cm)

5 5

Weight (lbs or kg)

172

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