CALIFORNIA
~ AESTHETICS ~

Client: Gregory Ortiz (6389) Dec 06, 2025

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

Legal First Name: Gregory
Legal Last Name: Ortiz
Date of Birth: 6/7/1996 (age 29)
Minor's Guardian Full Name, If Applicable:
Gender: Male
Street Address of Residence: 8645 Muller st
Apt./Unit #:
City of Residence: Downey
State of Residence: CA
Zip Code: 90241
Mobile Phone: (845) 401-1099
Email: sesosedits@gmail.com

2. The client allows MedScape GFE to perform the good faith exam and for the good faith exam to be released to: California Aesthetics
Appointment made? Yes

3. Please state the date and time of the appointment:

12/5/2025

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

☑ Stem Cell Hair Restoration

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

Have had selected treatment(s) before? No
Result of previous treatment(s)? Not applicable
Goal of requested treatment(s)? Select ALL that apply.
☑ Improve hair density and thickness
☑ Strengthen existing hair follicles
If needed, please explain further below:

6. "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	N/A	

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

No

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

	Name	Speciality
1	N/a	

9. 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

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

	Name of Medication and Dose:	Start Date:
1	Telmisartan	40MG

11. 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	Appendix remove	2009

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

	Type of Allergy:	Reaction:
1	N/a	

13. Vitals & Measurements

Height (ft/in or cm)
5ft 6

Weight (lbs or kg)
234

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?
Lose weight

If "other", please specify

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

☑ High Blood Pressure
135/75 my “normal”

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

☑ None of these

If "other", please specify

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

☑ None of these

If "other", please specify

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

☑ None of These

If "other", please specify

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

☑ None of these

If "other", please specify

19. 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.
N/a

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.

If "other", please specify

20. 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.
N/a

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

21. 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?
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?

If "other", please specify

22. Health History - Hair Health

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

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

If "other", please specify
Hims

23. Please answer the lifestyle questions below:

Average stress level:
High

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)
Around 4-8 glasses

Currently following any specific diet plan? If so, please specify which one(s): ☑ None of these

Do you have any tattoos located in or near the treatment area?
No

If YES on tattoos, please indicate the location. Put N/A if none.
N/a

24. 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 California 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 California Aesthetics medical director allows for off label treatment(s). For any off label administration and dosage, California Aesthetics must follow policies and procedures as approved by your clinics medical director. If California Aesthetics 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 for client is approved or denied to receive at California Aesthetics (select ALL that apply to visit):

☑ Stem Cell Hair Restoration

Treatment is deferred to California Aesthetics 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:

☑ 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 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 Dec 06, 2025

Good Faith Exam completed by the following MedScape GFE Practitioner:

Sunil Kurup, MD

*Signed by MedScape GFE on Dec 06, 2025 at 09:11 AM from IP 72.108.229.****