CALIFORNIA
~ AESTHETICS ~

Client: Natalie Payne (6254) Nov 21, 2025

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

Legal First Name: Natalie
Legal Last Name: Payne
Date of Birth: 1/25/1991 (age 34)
Minor's Guardian Full Name, If Applicable:
Gender: Female
Street Address of Residence: 7702 Melrose St
Apt./Unit #:
City of Residence: Buena Park
State of Residence: CA
Zip Code: 90621
Mobile Phone: (714) 808-2033
Email: nataliecuin01@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:

Dec 25 2025 at 9:30am

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

☑ Stem Cell Hair Restoration ☑ Botox Cosmetic

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.
☑ Support natural hair regrowth
☑ Improve hair density and thickness
☑ Strengthen existing hair follicles

If needed, please explain further below: Stop hair loss, achieve more hair growth

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	N/a

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

Yes

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

	Name	Speciality
1	Dr yang	Cardiologist
2	Dr quin	Therapist
3	Dr gutierrez	Primary dr

9. 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

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	Sacubitril 24-26mg	1/2 pill in the morning, 1/2 pill at night
2	Metoprolol 25mg	1/2 pill every night
3	Bariatríac multivitamin with iron	One a day
4	Calcium citrate with vitamin d	2 pills twice a day
5	Biotin 10,000	One pill a day
6	Zinc 50mg	One pill a day
7	B12 1000mcg	One pill a day
8	Nutafol	4 pills a day

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	C section, saddle back	4/14/25
2	Emergency hysterectomy saddle back	4/14/25
3	Blood transfusion, platelets transfusion, plasma transfusion saddle back	4/14/25
4	Takosubo cardiomyopothy Orange coast hospital	8/6/25
5	Gastric sleeve	8/6/25

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

	Type of Allergy:	Reaction:
1	N/a	N/a

13. Vitals & Measurements

Height (ft/in or cm)
5/5

Weight (lbs or kg)
158

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 loose more weight, tone my body, eventually Botox, be healthy

If "other", please specify

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

☑ Heart Condition
Takosubo cardiomyopathy

☑ Low Blood Pressure
Due to heart medications

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

☑ Migraine

If "other", please specify

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

☑ Constipation

If "other", please specify

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

☑ Hives
I take allergy medicine

☑ Rashes
I take allergy medication

If "other", please specify

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

☑ Anxiety
Occasional

☑ Depression
Post patrum

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?
Yes

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

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

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

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?
No

If "other", please specify

22. Health History - Hair Health

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

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

If "other", please specify
Nutrafol

23. 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?
Special occasions (a few times a year)

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): ☑ Healthy

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 ☑ Stem Cell Joint injection ☑ IV Hydration Therapy
☑ Botox Cosmetic ☑ Fillers ☑ T-Shape 2 ☑ Vitamin & Wellness Injections

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 Nov 21, 2025

Good Faith Exam completed by the following MedScape GFE Practitioner:

Danielle Trenelli, FNP-BC

*Signed by Danielle Trenelli on Nov 21, 2025 at 07:43 PM from IP 71.127.239.****