CALIFORNIA
~ AESTHETICS ~

Client: Christine Staffa (6277) Nov 25, 2025

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

Legal First Name: Christine
Legal Last Name: Staffa
Date of Birth: 09/17/1970 (age 55)
Minor's Guardian Full Name, If Applicable: christy staffa
Gender: Female
Street Address of Residence: 17833 La Lima Ln
Apt./Unit #:
City of Residence: Fountain valley
State of Residence: CA
Zip Code: 92708
Mobile Phone: (714) 794-7741
Email: cstaffa888@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:

11am 11-25-2025

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. 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

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
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	None	None

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	None	None

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	Levothyroxine	1983
2	Nutrafol	2024
3	Flexiril	Oct 2025

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	Implants 2002	
2	Maniscus tear 2019	

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

	Type of Allergy:	Reaction:
1	None	

13. Vitals & Measurements

Height (ft/in or cm)
5'6

Weight (lbs or kg)
165

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?
Slimmer tummy

If "other", please specify

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

☑ None of these

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):

☑ Cold Sores ☑ Dermatitis ☑ Eczema

If "other", please specify

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

☑ Hypothyroidism ☑ Prediabetes

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?
Yes

If yes, Please specify relation, type of cancer, and age at diagnosis. N/A for No.
Dad, 82. Prostate, remission

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.
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?
Yes

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

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?
Yes

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

If "other", please specify

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?
Occasionally (a few times a month)

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): ☑ **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 25, 2025

Good Faith Exam completed by the following MedScape GFE Practitioner:

Danielle Trenelli, FNP-BC

*Signed by Danielle Trenelli on Nov 25, 2025 at 09:29 AM from IP 71.127.239.****