



Client: Wanda Marshall (6289)

Dec 04, 2025

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

Legal First Name: <u>Wanda</u>	Legal Last Name: <u>Marshall</u>	Date of Birth: <u>06/18/1962 (age 63)</u>	
Minor's Guardian Full Name, If Applicable: <u>Wanda Marshall</u>	Gender: <u>Female</u>	Street Address of Residence: <u>191 Parkside Avenue</u>	Apt./Unit #: _____
City of Residence: <u>Syracuse</u>	State of Residence: <u>NY</u>	Zip Code: <u>13207</u>	Mobile Phone: <u>(315) 430-9287</u>
Email: <u>wandamknow@gmail.com</u>			

2. The client allows MedScape GFE to perform the good faith exam and for the good faith exam to be released to:
Inspired Beauty Med Spa

Appointment made?
Yes

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

December 1, 2025 6pm

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. Inspired Beauty Med Spa advises on treatment options within their clinic, scope of practice and protocols according to their medical director's guidelines.

☒ T-Shape 2 ☒ GLP-1 Injectables ☒ CryoTone® Skin Tightening
☒ Liposonic Skin Tightening & Fat Reduction

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

Have had selected treatment(s) before? <u>Unsure</u>	Result of previous treatment(s)? <u>Not applicable</u>
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Goal of requested treatment(s)? Select ALL that apply.

If needed, please explain further below:

- ☒ Support weight loss by reducing appetite and food cravings.
- ☒ Stimulate collagen and elastin production.
- ☒ Tighten skin and reduce fine lines.
- ☒ Break down stubborn fat cells non-surgically.

Area(s) to be treated (this good faith is good for one year; therefore, approval can be for future treatments wanted):

Will need to discuss

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**

Trying to become pregnant? ☒ **No**

Could possibly be pregnant? ☒ **No**

Currently breastfeeding? ☒ **No**

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

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

	Name of Medication:	Start Date:
1	Lipitor	

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:	Date and Year of Surgery/Hospitalization:
1	tonsils	1970
2	appendix	1974
3	hysterectomy	2005
4	bladder lift / bowel replacement	2017
5	steel plate in left forearm	2019

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

	Type of Allergy:	Reaction:
1	pennicilin	throat closes shut immediately

11. Vitals & Measurements

Height (ft/in or cm)

5' 1"

Weight (lbs or kg)

160

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?

shed stubborn fat - build muscle - gain energy - clear brain fog

If "other", please specify

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

☒ High Cholesterol
on med. still high

☒ Sinus Problems

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

☒ None of these

If "other", please specify

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

☒ Constipation
severe chronic constipation

☒ Intestinal Gas

☒ Irritable Bowel Syndrome

If "other", please specify

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

☒ Dry

If "other", please specify

16. 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

17. Health History - Sexual Health & Hormones

Do you experience sexual dysfunction (low libido, erectile difficulties, vaginal dryness, or other concerns)?

Yes

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

Yes

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

No

If "other", please specify

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

since the hysterectomy vag. dry / low lib. / not able to have an orgasam

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

No

18. Health History - Hair & Skin Health

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

Yes

Would you like a consultation about hair loss?

No

If "other", please specify

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

No

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

No

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.

daughter / thyroid / 18 yrs young

If "other", please specify

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

☒ **None of these**

If "other", please specify

21. 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)

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

Around 4-8 glasses

Recreational drugs?

None

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

22. 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 Inspired Beauty Med Spa. MedScape GFE does NOT condone any off label administration or dosing of ANY treatments. We will approve, however, it is ONLY depending on if Inspired Beauty Med Spa medical director allows for off label treatment(s). For any off label administration and dosage, Inspired Beauty Med Spa must follow policies and procedures as approved by your clinics medical director. If Inspired Beauty Med Spa 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 Inspired Beauty Med Spa (select ALL that apply to visit): ☒ **T-Shape 2** ☒ **GLP-1 Injectables** ☒ **CryoTone® Skin Tightening**

☒ **Liposonic Skin Tightening & Fat Reduction**

Treatment(s) deferred to Inspired Beauty Med Spa medical director's SOPs with the reason(s) for deferral. If no explanation(s) is/are necessary, please write "not applicable":

N/A

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":

N/A

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":

N/A

e-signature

Dec 04, 2025

Good Faith Exam completed by the following MedScape GFE Practitioner:



Signed by Carol Smith on Dec 04, 2025 at 11:50 AM from IP 98.169.56.***