Client: Lisa Tucker (6039) Nov 26, 2025

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

Legal First Name: Lisa
Legal Last Name: Tucker
Date of Birth: 7/13/1968 (age 57)
Minor's Guardian Full Name, If Applicable:
Gender: Female
Street Address of Residence: 3018 Holland Ln
Apt./Unit #:
City of Residence: Midlothian
State of Residence: TX
Zip Code: 76065
Mobile Phone: (214) 850-4866
Email: mothertuckerlt@gmail.com

2. The client allows MedScape GFE to perform the good faith exam and for the good faith exam to be released to: Modern Cryo & Wellness

Appointment made? Yes

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

Texas today at 6:00

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. Modern Cryo & Wellness advises on treatment options within their clinic, scope of practice and protocols according to their medical director's guidelines.

☑ T-Shape 2

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. ☑ Reduce Cellulite ☑ Tighten Skin

If needed, please explain further below:

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 and Dose:	Start Date:
1	Monjouro	2024
2	Magnesium	09/2025
3	Farxiga	09/2025

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	Bone Marrow Transplant	10/2016
2	C-section	2006
3	Gallbladder removed	2019

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

	Type of Allergy:	Reaction:
1	Codeine	Throw up

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

☑ Asthma ☑ Low Blood Pressure ☑ Night Sweats

Low blood pressure

12. Vitals & Measurements

Height (ft/in or cm)
5'2"

Weight (lbs or kg)
150

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

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

☑ Fatigue

If "other", please specify

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

☑ Irritable Bowel Syndrome

If "other", please specify

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

☑ None of These

If "other", please specify

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

☑ Past Cancer

MDS

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.

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

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.

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.)?

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?
Yes

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?
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): ☑ None of these

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 Modern Cryo & Wellness. MedScape GFE does NOT condone any off label administration or dosing of ANY treatments. We will approve, however, it is ONLY depending on if Modern Cryo & Wellness's medical director allows for off label treatment(s). For any off label administration and dosage, Modern Cryo & Wellness must follow policies and procedures as approved by your clinics medical director. If Modern Cryo & Wellness'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 Modern Cryo & Wellness (select ALL that apply to visit): ☑ T-Shape 2

Treatment(s) deferred to Modern Cryo & Wellness 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 26, 2025

Good Faith Exam completed by the following MedScape GFE Practitioner:

Danielle Trenelli, FNP-BC

*Signed by Danielle Trenelli on Nov 26, 2025 at 06:10 PM from IP 71.127.239.****