



**Client:** Amanda Vizcarra (6263)

Nov 24, 2025

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

Legal First Name: <u>Amanda</u>	Legal Last Name: <u>Vizcarra</u>	Date of Birth: <u>11/11/1979 (age 46)</u>	
Minor's Guardian Full Name, If Applicable: _____	Gender: <u>Female</u>	Street Address of Residence: <u>7008 Sweetwater Drive</u>	Apt./Unit #: _____
City of Residence: <u>Des Moines</u>	State of Residence: <u>IA</u>	Zip Code: <u>50320</u>	Mobile Phone: <u>(515) 419-1188</u>
Email: <u>amandaviz11@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: <u>Project Body Wellness</u>	Appointment made? <u>Yes</u>
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3. Please state the date and time of the appointment:

11 am Nov 22

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. Project Body 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? <u>No</u>	Result of previous treatment(s)? <u>Not applicable</u>
Goal of requested treatment(s)? Select ALL that apply. <input checked="" type="checkbox"/> <u>Fat loss reduction</u>	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	Pantoprazole 40 mg	2024
2	Lisinopril 10 mg	?
3	Amlodipine 5 mg	?
4	Bupropion 300 mg	?
5	Menofit supplement	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	Vaginal birth MercyOne DSM	Feb 2005
2	D and C Methodist DSM	Oct 2009
3	Hemroidectomy MercyOne DSM	2015
4	C section birth Methodist DSM	2012

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

	Type of Allergy:	Reaction:
1	None	

11. Vitals & Measurements

Height (ft/in or cm)

5 3

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

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

☒ High Blood Pressure

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):

☒ **Colitis**  
**Infectious 2 times in 2024**

If "other", please specify

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

☒ **Psoriasis**  
**1 flare up in 2014**

If "other", please specify

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

☒ **Anxiety** ☒ **Depression**

If "other", please specify

17. Health History - Cancer

Have you ever been diagnosed with cancer?  
**No**

Has any immediate family member (parents, siblings, children) been diagnosed with cancer?  
**Yes**

If "other", please specify

If yes, please specify type, date of diagnosis, and current status (active, in remission, or treated) N/A for No.  
**Na**

If yes, Please specify relation, type of cancer, and age at diagnosis. N/A for No.  
**Mom lymphoma in 2006 and 2011**

18. Health History - Mental Health & Emotional Well-Being

Do you have a history of depression, anxiety, or other mental health conditions?  
**Yes**

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

If "other", please specify

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

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

19. Health History - Sexual Health & Hormones

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

No

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.

Na

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

No

20. Health History - Hair & Skin Health

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

No

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.)?

Yes

21. Please answer the lifestyle questions below:

Average stress level:

Moderate

On average, how many days per week for alcohol consumption?

Occasionally (a few times a month)

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

Around 4-8 glasses

Smoke, vape, or chew tobacco?

Quit

Recreational drugs?

Weekends only

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 Project Body 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 Project Body Wellness medical director allows for off label treatment(s). For any off label administration and dosage, Project Body Wellness must follow policies and procedures as approved by your clinics medical director. If Project Body Wellness 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 Project Body Wellness (select ALL that apply to visit):

☒ **T-Shape 2**

Treatment is deferred to Project Body 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:

☒ **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 24, 2025

Good Faith Exam completed by the following MedScape GFE Practitioner:

*Danielle Trenelli, FNP-BC*

Signed by Danielle Trenelli on Nov 24, 2025 at 09:56 PM from IP 71.127.239.\*\*\*