REGENESIS
STEM CELL

Client: Kaylyn Smith (6299) Dec 03, 2025

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

Legal First Name: Kaylyn
Legal Last Name: Smith
Date of Birth: 8/16/1974 (age 51)
Minor's Guardian Full Name, If Applicable:
Gender: Female
Street Address of Residence: 1167 E Pioneer Rd
Apt./Unit #:
City of Residence: Draper
State of Residence: UT
Zip Code: 84020
Mobile Phone: (801) 856-8689
Email: kovardsmith@gmail.com

2. The client allows MedScape GFE to perform the good faith exam and for the good faith exam to be released to: Regenesis Wellness
Appointment made? No

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

☑ Peptide Therapy/Weight Loss

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

No

5. 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
Have you had a menstrual period within the last 12 months? ☑ No
When was your last menstrual period? 1/1/2018
Have you had any vaginal bleeding within the last 12 months? ☑ No
Have you ever had a Mammogram? ☑ Yes
When was your last Mammogram? N/A

Have you ever had a Pap smear? ☑ Yes

When was your last Pap smear?
N/A

Are you sexually active? ☑ No

Are you over the age of 50? ☑ Yes

Have you been told by your Provider that you have entered Perimenopause or Menopause? ☑ Yes

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

	Name of Medication:	Start Date:
1	Spironolacton	10/2025
2	Sertraline	1998
3	Liothyronine	2009
4	Topiramate	2021
5	Alendronate	2023
6	Levothyroxin	2012
7	Biotin	2024
8	Fexifenadin Hydrochloride	2022

7. 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	C-section	2001
2	Hysterectomy	2018

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

	Type of Allergy:	Reaction:
1	Sulfa	Hives
2	Neoprene	Hives

9. Vitals & Measurements

Height (ft/in or cm)
5

Weight (lbs or kg)
4

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?
Healthy

If "other", please specify
Loose weight

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

☑ Asthma
Mild

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

☑ Migraine
Once a month or so
If "other", please specify

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

☑ Celiac Disease

If "other", please specify

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

☑ None of These
client denies
If "other", please specify

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

☑ Anxiety ☑ Depression

If "other", please specify

15. 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.
N/A

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?
Yes

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

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 - 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

18. 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?

None

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): ☑ Gluten-Free

19. 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 Regenesis 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 Regenesis Wellness medical director allows for off label treatment(s). For any off label administration and dosage, Regenesis Wellness must follow policies and procedures as approved by your clinics medical director. If Regenesis 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(s) client is approved and/or denied to receive at Regenesis Wellness (select ALL that apply to visit):

☑ Peptide Therapy/Weight Loss

Treatment(s) deferred to Regenesis 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 Dec 03, 2025

Good Faith Exam completed by the following MedScape GFE Practitioner:

Tangular Barnes, FNP-BC

*Signed by Tangular Barnes on Dec 03, 2025 at 09:22 AM from IP 45.17.88.****