REGENESIS
STEM CELL

Client: Cara Person (6287) Nov 25, 2025

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

Legal First Name: Cara
Legal Last Name: Person
Date of Birth: 7/13/1978 (age 47)
Minor's Guardian Full Name, If Applicable:
Gender: Female
Street Address of Residence: 6495 S Mount Whitney Ln
Apt./Unit #:
City of Residence: Salt Lake City
State of Residence: UT
Zip Code: 84118
Mobile Phone: (801) 661-3071
Email: caraboo13@yahoo.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.

☑ Hormone Replacement Therapy

4. Please answer the questions below relating to Hormone Replacement Therapy treatment.

Have had selected treatment(s) before? Yes
Result of previous treatment(s)? Not applicable
Goal of requested treatment(s)? Select ALL that apply.
☑ Balance hormone levels
☑ Increase energy and reduce fatigue
☑ Reduce hot flashes and night sweats
If needed, please explain further below:

5. "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	Estradiol	Current

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

Yes

7. "Yes" for medical care was selected. Please list the provider's name(s) and their speciality.

	Name	Speciality
1	Michelle Grubb	Gynecologist

8. For female assigned gender at birth:

Currently pregnant? ☑ No

Could possibly be pregnant? ☑ No

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

When was your last menstrual period?
9/8/2013

Have you ever had a Mammogram? ☑ Yes

Have you ever had a Pap smear? ☑ Yes

Are you sexually active? ☑ Yes

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

Trying to become pregnant? ☑ No

Currently breastfeeding? ☑ No

Have you had a menstrual period within the last 12 months? ☑ No

Have you had any vaginal bleeding within the last 12 months? ☑ No

When was your last Mammogram?
October 2025

When was your last Pap smear?
12 years ago

Are you over the age of 50? ☑ No

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

	Name of Medication:	Start Date:
1	Clonidine ER 0.1mg	12/10/2020
2	Estradiol 0.5 mg	October 2025
3	Quetiapine 400 mg	12/10/2020
4	Venlafaxine ER 75mg	08/05/2018
5	Multivitamin	2020

10. 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	Hysterectomy	2013
2	Gull bladder	2007
3	Back surgery	2002
4	Back surgery	2014
5	C section	2009

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

	Type of Allergy:	Reaction:
1	Sulfa	Nausea rash vomiting
2	Lamictal	Rash/ hospitalization

12. Vitals & Measurements

Height (ft/in or cm)
5’6”

Weight (lbs or kg)
130

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?
Run 2 1/2 miles a day

If "other", please specify

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

☑ None of these

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

☑ None of these

If "other", please specify

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

☑ Bloating ☑ Colitis ☑ Constipation

If "other", please specify

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

☑ Cold Sores ☑ Dry

If "other", please specify

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

☑ Anxiety ☑ Depression

If "other", please specify

18. 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.
No

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.
No

If "other", please specify

19. 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

20. Health History - Hair Health

Do you currently experience hair loss, thinning, or shedding?
No

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

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?
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): ☑ 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 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):
☑ Stem Cell Hair Restoration ☑ Hormone Replacement Therapy ☑ Regenerative IV Therapy
☑ Sexual Wellness Therapy ☑ 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 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 05:04 PM from IP 71.127.239.****