REPLENISH HEALTH SPA
AESTHETICS & HAIR RESTORATION

Client: Diane Rogers (6193) Dec 03, 2025

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

Legal First Name: Diane
Legal Last Name: Rogers
Date of Birth: 05/06/1956 (age 69)
Minor's Guardian Full Name, If Applicable:
Gender: Female
Street Address of Residence: 1901 Conifer Circle
Apt./Unit #:
City of Residence: Charlotte
State of Residence: NC
Zip Code: 28213
Mobile Phone: (704) 842-3402
Email: rogersdiane95@yahoo.com

2. The client allows MedScape GFE to perform the good faith exam and for the good faith exam to be released to: Replenish Health Spa
Appointment made? Yes

3. Please state the date and time of the appointment:
NC 12pm

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. Replenish Health Spa advises on treatment options within their clinic, scope of practice and protocols according to their medical director's guidelines.
☑ Hair Restoration

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. ☑ Not applicable
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:	Start Date:
1	Gemsta	June 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:	Date and Year of Surgery/Hospitalization:
1	None	None

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

	Type of Allergy:	Reaction:
1	None	None

11. Vitals & Measurements

Height (ft/in or cm)
5'9"

Weight (lbs or kg)
175

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):

☑ None of these
client denies

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

☑ None of these
client denies

If "other", please specify

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

☑ None of these
client denies

If "other", please specify

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

☑ None of These
client denies

If "other", please specify

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

☑ None of these
client denies

If "other", please specify

17. 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.

If "other", please specify

18. 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.
No

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

19. 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.
None

Have you noticed changes in your energy, mood, or sleep patterns that you think may be hormone-related?
No

Have you ever had a hormone evaluation (testosterone, estrogen, thyroid, cortisol, etc.)?
No

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

If "other", please specify

20. Please answer the lifestyle questions below:

Average stress level:
Moderate

Tobacco products (including vaping)?
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)
None

Currently following any specific diet plan? If so, please specify which one(s): ☑ Gluten-Free

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 Replenish Health 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 Replenish Health Spa's medical director allows for off label treatment(s). For any off label administration and dosage, Replenish Health Spa must follow policies and procedures as approved by your clinics medical director. If Replenish Health Spa'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 deferred to receive at Replenish Health Spa's (select ALL that apply to visit): ☑ Hair Restoration

Treatment(s) deferred to Replenish Health Spa's 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 09:42 AM from IP 45.17.88.****