REVIVA
AESTHETICS

Client: Austin Sutor (6525) Dec 16, 2025

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

Legal First Name:	Legal Last Name:	Date of Birth:
Austin	Sutor	9/2/1994 (age 31)

Minor's Guardian Full Name, If Applicable:	Gender:	Street Address of Residence:	Apt./Unit #:
	Male	4101 McBrine Pl	

City of Residence:	State of Residence:	Zip Code:	Mobile Phone:
Austin	TX	78746	(443) 846-9304

Email:
austin@houseofdreamr.com

2. The client allows MedScape GFE to perform the good faith exam and for the good faith exam to be released to:
Reviva Aesthetics

Appointment made?
Yes

3. Please state the date and time of the appointment:
December 21 at 10am

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. Reviva Aesthetics advises on treatment options within their clinic, scope of practice and protocols according to their medical director's guidelines.
☑ Stem Cell 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.
☑ Other

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

	Name of Medication and Dose:	Start Date:
1	None	

8. 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	NA	

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

	Type of Allergy:	Reaction:
1	Penicillin	Anafalaxis

10. Vitals & Measurements

Height (ft/in or cm)
6'4

Weight (lbs or kg)
185

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

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

☑ None of these
client denies

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

☑ None of these
client denies

If "other", please specify

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

☑ None of these
client denies

If "other", please specify

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

☑ None of These
client denies

If "other", please specify

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

☑ None of these
client denies

If "other", please specify

16. 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.
NA

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.
NA

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.
NA

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

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

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.
NA

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?
Yes

If "other", please specify

19. 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

Do you have any tattoos located in or near the treatment area?
No

If YES on tattoos, please indicate the location. Put N/A if none.
NA

20. 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 Reviva Aesthetics. MedScape GFE does NOT condone any off label administration or dosing of ANY treatments. We will approve, however, it is ONLY depending on if Reviva Aesthetics's medical director allows for off label treatment(s). For any off label administration and dosage, Reviva Aesthetics must follow policies and procedures as approved by your clinics medical director. If Reviva Aesthetics'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 Reviva Aesthetics's (select ALL that apply to visit):
☑ Stem Cell Hair Restoration

Treatment(s) deferred to Reviva Aesthetics'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 16, 2025

Good Faith Exam completed by the following MedScape GFE Practitioner:

Tangular Barnes, FNP-BC

*Signed by Tangular Barnes on Dec 16, 2025 at 06:15 PM from IP 45.17.88.****