



USCryotherapy

FASTER RECOVERY • BETTER HEALTH

Client: Garrett Dagneau (6278)

Nov 25, 2025

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

Legal First Name: <u>Garrett</u>	Legal Last Name: <u>Dagneau</u>	Date of Birth: <u>11/18/1963 (age 62)</u>	
Minor's Guardian Full Name, If Applicable: _____	Gender: <u>Male</u>	Street Address of Residence: <u>3694 Otter Brook Loop</u>	Apt./Unit #: _____
City of Residence: <u>Discovery Bay</u>	State of Residence: <u>CA</u>	Zip Code: <u>94505</u>	Mobile Phone: <u>(925) 437-4207</u>
Email: <u>gdagneau@att.net</u>			

2. The client allows MedScape GFE to perform the good faith exam and for the good faith exam to be released to:
US Cryotherapy Danville/San Ramon

Appointment made?
Yes

3. Please state the date and time of the appointment:
11/28/2025, 3:00 pm

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. US Cryotherapy Danville/San Ramon advises on treatment options within their clinic, scope of practice and protocols according to their medical director's guidelines.

☒ **T-Shape 2 Cellulite Reduction and/or Skin Tightening**

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.
☒ **Reduce Cellulite** ☒ **Tighten Skin**

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	
2	None	
3	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	Testicular	1995
2	Left eye, titanium	2023

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

	Type of Allergy:	Reaction:
1	None	

10. Vitals & Measurements

Height (ft/in or cm)
5'11

Have you noticed any recent changes in your weight?
No

If "other", please specify

Weight (lbs or kg)
202

Do you have personal wellness or body goals you'd like us to know about?
No

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

☒ None of these

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

☒ Bell's Palsy

If "other", please specify

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

☒ **None of these**

If "other", please specify

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

☒ **None of These**

If "other", please specify

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

☒ **Past Cancer**

Testicular& melanoma

If "other", please specify

16. Health History - Cancer

Have you ever been diagnosed with cancer?

Yes

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

Testicular and melanoma, treated

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

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.

None

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

18. Health History - Sexual Health & Hormones

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

Yes

If yes, please specify. N/A for none.

Low labido

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. Health History - Hair & Skin Health

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

No

Have you tried any treatments for hair loss in the past?

No

Would you like a consultation about hair loss?

No

Do you have a history of skin disorders (acne, eczema, psoriasis, etc.)?

No

If "other", please specify

20. 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?

Occasionally (a few times a month)

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**

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 US Cryotherapy Danville/San Ramon. MedScape GFE does NOT condone any off label administration or dosing of ANY treatments. We will approve, however, it is ONLY depending on if US Cryotherapy Danville/San Ramon medical director allows for off label treatment(s). For any off label administration and dosage, US Cryotherapy Danville/San Ramon must follow policies and procedures as approved by your clinics medical director. If US Cryotherapy Danville/San Ramon 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 treatment at US Cryotherapy Danville/San Ramon (select ALL that apply to visit): ☒ **Approved for T-Shape 2 Cellulite Reduction and/or Skin Tightening**

Treatment(s) deferred to US Cryotherapy Danville/San Ramon 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 09:24 AM from IP 71.127.239.***