Plastic & Reconstructive Surgery Cosmetic Surgery Skin Cancer Surgery

682 Hemlock Street, Suite 230 Macon, Georgia 31201 (478) 742-4847

## **FAMILY HISTORY**

| Family F                                                   | History Illness  | es:                 |                    |                                        |                                  |  |
|------------------------------------------------------------|------------------|---------------------|--------------------|----------------------------------------|----------------------------------|--|
| Please te                                                  | ll us about an   | y family members wh | o have or have had | l major health problems:               | ☐ Unknown/Adopted                |  |
| Father:                                                    | ☐ Alive          | ☐ Deceased ☐ Y      | Year of birth      |                                        | -                                |  |
|                                                            | Health problems: |                     |                    |                                        |                                  |  |
| Mother:                                                    | ☐ Alive          | ☐ Deceased ☐ Y      |                    |                                        |                                  |  |
|                                                            | Health problems: |                     |                    |                                        |                                  |  |
| Siblings:  Brother  Sister  Alive  Deceased  Year of birth |                  |                     |                    |                                        |                                  |  |
| Health problems:                                           |                  |                     |                    |                                        |                                  |  |
|                                                            |                  |                     |                    |                                        |                                  |  |
|                                                            |                  |                     |                    |                                        |                                  |  |
|                                                            |                  |                     |                    |                                        |                                  |  |
|                                                            |                  |                     |                    |                                        |                                  |  |
| Print Patient Name/Representative                          |                  |                     | _                  | 1                                      | Patient Signature/Representative |  |
| Date                                                       | of Birth         |                     | _                  | —————————————————————————————————————— |                                  |  |

