CHILD FAMILY HISTORY FORM
KanLovKids Program

Please fill in information about your child in the sections below. Thank you!

Date _____ Child's Name _____ DOB _____

Gestational age _____ Birth weight _____
_____ Single _____ Twins _____ Triplets

Past Ocular History

- Your child's ocular history (e.g., age of symptoms onset; eye turns; eye surgeries [list and note year]; eye-poking; etc.):

- Parent description of functional vision (e.g., response to parent's face; to toys or objects; tracking favorite color; etc.):

- Eye medications:

- Any significant family ocular history (eye diseases – eye turns, lazy eye, eye patching, thick glasses, medical problems or disabilities in the family, etc.):

Past Medical History

1. Perinatal History

a. **Mother** (e.g., general health of mother during pregnancy; general nutritional status; estimated date of confinement; drugs-alcohol-medications during pregnancy; trauma; multiple births; infections such as CMV, AIDS, toxoplasmosis, maternal rubella; steroid use; hypertension; pre-eclampsia):

b. **Your child's** gestational age at birth. Birth weight. Did the baby move in utero? How was the birth? Was resuscitation required? Other congenital anomalies?):

2. Postnatal History

a. Nursery Stay (retinopathy of prematurity risk factors, especially low birth weight and exacerbated by several factors including, sepsis, transfusions, unstable course; cortical visual impairment risk factors including above, and history of intraventricular hemorrhage):

b. Current Medical Problems (seizures, trauma, other congenital anomalies; birth marks, ADHD, hearing, speech, hospitalization, frequent visits to the doctor, surgeries-[please list and note date of], other diagnosis, etc.):

3. Developmental History

When did your child raise his/her head? Crawl? Walk? Reach/grasp object –when?

4. Medications

5. Allergies

6. Educational Issues

How is your child performing in early intervention services/school? Explain type of home/school s/he participates in or attends?

7. Other Interventions

What services Is your child receiving (e.g., occupational or physical therapy, speech therapy, services from a teacher of the blind or visually impaired, orientation or mobility, etc.)?

Lawrence, L. M. (2003). *Pediatric Low Vision.* Project ORBIS International Inc. http://telemedicine.orbis.org/bins/volume_page.asp?cid=1-861-863-862&lang=1

Hatton, D.D., & Campbell, A.F. (2003). *Interpreting eye reports.* Chapel Hill, NC: Early Intervention Training Center for Infants and Toddlers with Visual Impairments, FPG Child Development Institute, UNC-CH.

rev. 2011