

**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?):

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**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](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.

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