



# Pediatric Bleeding Questionnaire (PBQ)

Date \_\_\_\_\_ Patient Number \_\_\_\_\_

Patient Name \_\_\_\_\_

Gender Male  Female

Age \_\_\_\_\_ DOB (dd/mm/yy) \_\_\_\_\_

Ethnic Background of: Father \_\_\_\_\_ Mother \_\_\_\_\_

Presenting complaint of bleeding or bruising today? Yes  No

Ever been diagnosed with a bleeding disorder? Yes  Diagnosis: \_\_\_\_\_  
No

Total # of 1<sup>st</sup> degree family members  # of 1<sup>st</sup> degree family members studied

# of diagnosed 1<sup>st</sup> degree family members  Notes:

ABO Blood Group A  B  AB  O  Rh -  Rh +

Present questionnaire completed by Father  Mother  Patient

Menarche N/A  Yes  Age of menarche: \_\_\_\_\_  
No

Are you currently taking oral contraceptive pills? Yes  Brand Name: \_\_\_\_\_  
No

Specify any herbals and/or medications that you have taken in the past 30 days:

Name	Dose	Route	Frequency	Duration
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Past Medical History: \_\_\_\_\_

Bleeding symptoms		
Epistaxis	No <input type="checkbox"/>	If Yes, Trivial <input type="checkbox"/> Significant <input type="checkbox"/>
<b>AVERAGE PRESENTATION</b>		
Age of maximum severity	<input type="checkbox"/> 0 - 4 years <input type="checkbox"/> 4 - 8 years <input type="checkbox"/> 8 - 12 years <input type="checkbox"/> 12 - 16 years <input type="checkbox"/> 16 - 20 years	
Number episodes/year	<input type="checkbox"/> < 1 <input type="checkbox"/> 1 - 5 <input type="checkbox"/> 6 - 12 <input type="checkbox"/> > 12	
Duration of average single episode	<input type="checkbox"/> < 1 minute <input type="checkbox"/> 1-10 minutes <input type="checkbox"/> > 10 minutes	
Spontaneous?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Both nostrils?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
After drug ingestion (e.g. aspirin)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Seasonal correlation	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cessation	Specify: <input type="checkbox"/> spontaneous <input type="checkbox"/> after compression <input type="checkbox"/> by medical intervention	
<b>REPORT TREATMENT OF THE MOST SEVERE EPISODE</b>		
Required medical attention?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please specify:	<input type="checkbox"/> Consultation only <input type="checkbox"/> Packing # of times <input type="checkbox"/> Cauterization # of times <input type="checkbox"/> Antifibrinolytics # of times <input type="checkbox"/> Desmopressin # of times <input type="checkbox"/> Replacement therapy # of times <input type="checkbox"/> Blood transfusion # of times	
Notes		

## Pediatric Bleeding Questionnaire (PBQ)

<b>Cutaneous symptoms</b>	No <input type="checkbox"/>	If Yes,	Trivial <input type="checkbox"/>	Significant <input type="checkbox"/>
<b>AVERAGE PRESENTATION</b>				
Type	<input type="checkbox"/> Petechiae <input type="checkbox"/> Bruises <input type="checkbox"/> Hematomas			
Location of lesions (if any)	<input type="checkbox"/> Exposed sites <input type="checkbox"/> Unexposed sites <input type="checkbox"/> Both			
Size of average	<input type="checkbox"/> < 1 cm <input type="checkbox"/> 1 – 5 cm <input type="checkbox"/> > 5 cm			
Minimal or no trauma	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
<b>REPORT TREATMENT OF THE MOST SEVERE EPISODE</b>				
Required medical attention?	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
If yes, please specify:				
Consultation only	<input type="checkbox"/>			
Notes				

<b>Bleeding from minor wounds</b>	No <input type="checkbox"/>	If Yes,	Trivial <input type="checkbox"/>	Significant <input type="checkbox"/>
<b>AVERAGE PRESENTATION</b>				
Number episodes/year	<input type="checkbox"/> < 1 <input type="checkbox"/> 1 - 5 <input type="checkbox"/> 6 - 12 <input type="checkbox"/> > 12			
Duration of average single episode	<input type="checkbox"/> ≤ 5 mins. <input type="checkbox"/> > 5 mins.			
<b>REPORT TREATMENT OF THE MOST SEVERE EPISODE</b>				
Required medical attention?	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
If yes, please specify:				
Consultation or Steri-strips	<input type="checkbox"/> # of times			
Surgical hemostasis	<input type="checkbox"/> # of times			
Antifibrinolytics	<input type="checkbox"/> # of times			
Desmopressin	<input type="checkbox"/> # of times			
Replacement therapy	<input type="checkbox"/> # of times			
Blood transfusion	<input type="checkbox"/> # of times			
Notes				

## Pediatric Bleeding Questionnaire (PBQ)

<b>Oral cavity bleeding</b>	No <input type="checkbox"/>	If Yes,	Trivial <input type="checkbox"/>	Significant <input type="checkbox"/>
<b>AVERAGE PRESENTATION</b>				
Type of bleeding	<input type="checkbox"/> Tooth eruption/loss <input type="checkbox"/> Gums, spontaneous <input type="checkbox"/> Gums, after brushing <input type="checkbox"/> Prolonged bleeding after bites to lip & tongue <input type="checkbox"/> Hemorrhagic bullae			
<b>REPORT TREATMENT OF THE MOST SEVERE EPISODE</b>				
Required medical attention?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
If yes, please specify:	<input type="checkbox"/> Consultation only <input type="checkbox"/> Surgical hemostasis # of times <input type="checkbox"/> Antifibrinolytics # of times <input type="checkbox"/> Desmopressin # of times <input type="checkbox"/> Replacement therapy # of times <input type="checkbox"/> Blood transfusion # of times			
Notes				

<b>Tooth extraction</b>	No <input type="checkbox"/>	If Yes,	Trivial <input type="checkbox"/>	Significant <input type="checkbox"/>
Total # of teeth extracted	<input type="text"/> <input type="text"/>	# of teeth extracted followed by bleeding	<input type="text"/> <input type="text"/>	

<b>MOST SEVERE OCCURRENCE</b>			
Age at extraction	<input type="text"/> <input type="text"/>	Type of extraction	<input type="checkbox"/> Deciduous <input type="checkbox"/> Permanent
Prophylaxis before extraction?	<input type="checkbox"/> None <input type="checkbox"/> Antifibrinolytics <input type="checkbox"/> Desmopressin <input type="checkbox"/> Replacement therapy		
Bleeding after extraction?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Actions taken to control bleeding	<input type="checkbox"/> None <input type="checkbox"/> Consultation only <input type="checkbox"/> Resuturing <input type="checkbox"/> Packing <input type="checkbox"/> Antifibrinolytics <input type="checkbox"/> Desmopressin <input type="checkbox"/> Replacement therapy <input type="checkbox"/> Blood transfusion		
Notes			

# Pediatric Bleeding Questionnaire (PBQ)

<b>Gastrointestinal bleeding</b>		No <input type="checkbox"/>	Yes <input type="checkbox"/>
<b>AVERAGE PRESENTATION</b>			
# of episodes	<input type="text"/> <input type="text"/>		
Type of bleeding	<input type="checkbox"/> Hematemesis <input type="checkbox"/> Melena <input type="checkbox"/> Hematochezia		
Presence of associated GI disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	<input type="checkbox"/> Gastritis/ulcer <input type="checkbox"/> Colitis <input type="checkbox"/> Mallory-Weiss tear <input type="checkbox"/> Vascular malformations <input type="checkbox"/> Other		
<b>REPORT TREATMENT OF THE MOST SEVERE EPISODE</b>			
Required medical attention?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes, please specify:	<input type="checkbox"/> Consultation only <input type="checkbox"/> Surgical hemostasis # of times <input type="checkbox"/> Antifibrinolytics # of times <input type="checkbox"/> Desmopressin # of times <input type="checkbox"/> Replacement therapy # of times <input type="checkbox"/> Blood transfusion # of times		
Notes			

## Pediatric Bleeding Questionnaire (PBQ)

<b>Surgery</b>	No <input type="checkbox"/>	If Yes,	Trivial <input type="checkbox"/>	Significant <input type="checkbox"/>
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Total # of surgeries   # of surgeries followed by bleeding    
 Specify

<b>MOST SEVERE OCCURRENCE</b>	
Age at surgery	<input type="text"/> <input type="text"/> <div style="display: inline-block; vertical-align: top; margin-left: 20px;">                     Type of surgery Specify                 </div>
Prophylaxis before surgery?	<input type="checkbox"/> None <input type="checkbox"/> Antifibrinolytics <input type="checkbox"/> Desmopressin <input type="checkbox"/> Replacement therapy
Bleeding after surgery?	Yes <input type="checkbox"/> <span style="margin-left: 150px;">No <input type="checkbox"/></span>
Actions taken to control bleeding	<input type="checkbox"/> None <input type="checkbox"/> Consultation only <input type="checkbox"/> Resuturing/surgical <input type="checkbox"/> Antifibrinolytics <input type="checkbox"/> Desmopressin <input type="checkbox"/> Replacement therapy <input type="checkbox"/> Blood transfusion
Notes	

## Pediatric Bleeding Questionnaire (PBQ)

<b>Menorrhagia</b>	N/A <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
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Duration of average menstruation (days)        Duration of heavy (days)

How often do you change your pads/tampons \_\_\_\_\_ hours      on heaviest days \_\_\_\_\_ hours  
 \_\_\_\_\_ hours      on average days \_\_\_\_\_ hours

What type of feminine product do you use? (i.e. panty liner, super absorbency tampon etc.)

Comments

<b>MOST SEVERE PRESENTATION</b>	
Age of maximum severity	<input type="checkbox"/> 8-12 <input type="checkbox"/> 13-16 <input type="checkbox"/> 17-20 <input type="checkbox"/> >20 yrs
Required medical attention?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please specify:	
Consultation only	<input type="checkbox"/>
Pill use	<input type="checkbox"/>
Antifibrinolytics	<input type="checkbox"/>
Dilatation & curettage	<input type="checkbox"/> # of times
Iron therapy	<input type="checkbox"/>
Desmopressin	<input type="checkbox"/>
Replacement therapy	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/> # of times
Hysterectomy	<input type="checkbox"/>
Notes	

# Pediatric Bleeding Questionnaire (PBQ)

<b>Post-partum hemorrhage</b> N/A <input type="checkbox"/>	No <input type="checkbox"/>	If Yes,	Trivial <input type="checkbox"/>	Significant <input type="checkbox"/>
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Total # of deliveries   # of deliveries followed by bleeding

<b>MOST SEVERE OCCURRENCE</b>	
Age at delivery <input type="text"/> <input type="text"/>	Mode of delivery <input type="checkbox"/> spontaneous <input type="checkbox"/> assisted <input type="checkbox"/> c-section
Prophylaxis before delivery	<input type="checkbox"/> None <input type="checkbox"/> Antifibrinolytics <input type="checkbox"/> Desmopressin <input type="checkbox"/> Replacement therapy
Bleeding after delivery?	Yes <input type="checkbox"/> <span style="margin-left: 150px;">No <input type="checkbox"/></span>
Actions taken to control bleeding	<input type="checkbox"/> None <input type="checkbox"/> Consultation only <input type="checkbox"/> Resuturing/surgical <input type="checkbox"/> Antifibrinolytics <input type="checkbox"/> Desmopressin <input type="checkbox"/> Replacement therapy <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Hysterectomy
Notes	

<b>Muscle hematomas</b>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
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Total #

<b>MOST SEVERE PRESENTATION</b>		
Please specify type & location		
Post-trauma?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Prophylaxis?	<input type="checkbox"/> None <input type="checkbox"/> Antifibrinolytics <input type="checkbox"/> Desmopressin <input type="checkbox"/> Replacement therapy	
Required medical attention?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please specify:		
Surgical intervention	<input type="checkbox"/>	
Desmopressin	<input type="checkbox"/>	
Replacement therapy	<input type="checkbox"/>	
Blood transfusion	<input type="checkbox"/>	
Notes		

<b>Hemarthrosis</b>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
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Total #

<b>MOST SEVERE PRESENTATION</b>		
Please specify type & location		
Post-trauma?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Prophylaxis?	<input type="checkbox"/> None <input type="checkbox"/> Antifibrinolytics <input type="checkbox"/> Desmopressin <input type="checkbox"/> Replacement therapy	
Required medical attention?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please specify:		
Surgical intervention	<input type="checkbox"/>	
Desmopressin	<input type="checkbox"/>	
Replacement therapy	<input type="checkbox"/>	
Blood transfusion	<input type="checkbox"/>	
Notes		

<b>CNS bleeding</b>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
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If yes, type of bleeding			
Subdural, any intervention	<input type="checkbox"/>	Intracerebral, any intervention	<input type="checkbox"/>

<b>Other bleeding</b>		No <input type="checkbox"/>	Yes <input type="checkbox"/>
If yes, type of bleeding			
Umbilical stump	<input type="checkbox"/>	Cephalohematoma	<input type="checkbox"/>
Bleeding at circumcision	<input type="checkbox"/>	Venipuncture bleeding	<input type="checkbox"/>
Male, not circumcised <input type="checkbox"/>			
Male, circumcised <input type="checkbox"/>			
Female <input type="checkbox"/>			
Conjunctival hemorrhage	<input type="checkbox"/>	Hematuria, macroscopic	<input type="checkbox"/>
<b>MOST SEVERE PRESENTATION</b>			
Please specify type			
Required medical attention?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes, please specify:			
Consultation only	<input type="checkbox"/>		
Iron therapy	<input type="checkbox"/> # of times		
Surgical hemostasis	<input type="checkbox"/> # of times		
Antifibrinolytics	<input type="checkbox"/> # of times		
Desmopressin	<input type="checkbox"/> # of times		
Replacement therapy	<input type="checkbox"/> # of times		
Blood transfusion	<input type="checkbox"/> # of times		
Notes			

**Other bleeding (continued)**

<b>MOST SEVERE PRESENTATION</b>		
Please specify type		
Required medical attention?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please specify:		
Consultation only	<input type="checkbox"/>	
Iron therapy	<input type="checkbox"/>	# of times
Surgical hemostasis	<input type="checkbox"/>	# of times
Antifibrinolytics	<input type="checkbox"/>	# of times
Desmopressin	<input type="checkbox"/>	# of times
Replacement therapy	<input type="checkbox"/>	# of times
Blood transfusion	<input type="checkbox"/>	# of times
Notes		

<b>MOST SEVERE PRESENTATION</b>		
Please specify type		
Required medical attention?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please specify:		
Consultation only	<input type="checkbox"/>	
Iron therapy	<input type="checkbox"/>	# of times
Surgical hemostasis	<input type="checkbox"/>	# of times
Antifibrinolytics	<input type="checkbox"/>	# of times
Desmopressin	<input type="checkbox"/>	# of times
Replacement therapy	<input type="checkbox"/>	# of times
Blood transfusion	<input type="checkbox"/>	# of times
Notes		