



Pediatric Bleeding Questionnaire (PBQ) (39)

Subject data

Date

Child's Name

Parent's Name

Address

Email

Phone Number

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 ☐

No ☐

Diagnosis:

Total # of 1st degree family members ☐☐ # of 1st degree family members studied ☐☐

of diagnosed 1st degree family members ☐☐ Notes:

ABO Blood Group

A ☐

B ☐

AB ☐

O ☐

Rh - ☐

Rh + ☐

Present questionnaire completed by

Father ☐

Mother ☐

Subject ☐

Menarche N/A ☐

Yes ☐

No ☐

Age of menarche:

Are you currently taking oral contraceptive pills?

Yes ☐

No ☐

Brand Name:

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

Name

Dose

Route

Frequency Duration

Past Medical History

Temperature (day of blood work)

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

Notes

Cutaneous symptoms Significant <input type="checkbox"/>	No <input type="checkbox"/>	If Yes,	Trivial <input type="checkbox"/>
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AVERAGE PRESENTATION

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"/>	

REPORT TREATMENT OF THE MOST SEVERE EPISODE

Required medical attention? Yes ☐ No ☐

If yes, please specify: Consultation only ☐

Notes

Bleeding from minor wounds	No <input type="checkbox"/>	If Yes,	Trivial <input type="checkbox"/>
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Significant ☐

AVERAGE PRESENTATION

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		

REPORT TREATMENT OF THE MOST SEVERE EPISODE

If yes, please specify: Consultation only ☐

Packing <input type="checkbox"/>	# of times	Cauterization <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

Oral cavity bleeding Significant <input type="checkbox"/>	No <input type="checkbox"/>	If Yes,	Trivial <input type="checkbox"/>
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AVERAGE PRESENTATION

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	

REPORT TREATMENT OF THE MOST SEVERE EPISODE

If yes, please specify:		Consultation only <input type="checkbox"/>	
Packing <input type="checkbox"/>	# of times	Cauterization <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			

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

MOST SEVERE OCCURRENCE

Age at extraction <input type="checkbox"/> <input type="checkbox"/>	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

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

Notes

Surgery	No <input type="checkbox"/>	If Yes,
Trivial <input type="checkbox"/> Significant <input type="checkbox"/>		

Total # of surgeries # of surgeries followed by bleeding

Specify

MOST SEVERE OCCURRENCEAge at surgery Type of surgery:
specifyProphylaxis before surgery? ☐ None ☐ Antifibrinolytics ☐ Desmopressin ☐ Replacement therapyBleeding after surgery? Yes ☐ No ☐Actions taken to control bleeding ☐ None ☐ Consultation only ☐ Resuturing/surgical☐ Antifibrinolytics ☐ Desmopressin☐ Replacement therapy ☐ Blood transfusion

Notes

Menorrhagia	N/A <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Duration of average menstruation (days)	<input type="text"/>	Duration of heavy (days) <input type="text"/>	
How often do you change your pads/tampons		on heaviest days <input type="text"/> hours	on average days <input type="text"/> hours
What type of feminine product do you use? (i.e. panty liner, super absorbency tampon etc.)			
Comments			

MOST SEVERE PRESENTATION

Age of maximum severity ☐ 8-12 ☐ 13-16 ☐ 17-20 ☐ >20 yrs

Required medical attention? Yes ☐ No ☐

If yes, please specify:

Pill use ☐ Antifibrinolytics ☐ Dilatation & curettage ☐ # of times

Iron therapy ☐ Desmopressin ☐ Replacement therapy ☐

Blood transfusion ☐ # of times Hysterectomy ☐

Notes

Post-partum hemorrhage		N/A <input type="checkbox"/>	No <input type="checkbox"/>	If Yes,	Trivial <input type="checkbox"/>
Significant <input type="checkbox"/>					
Total # of deliveries	<input type="checkbox"/> <input type="checkbox"/>	# of deliveries	followed by bleeding		<input type="checkbox"/> <input type="checkbox"/>
MOST SEVERE OCCURRENCE					
Age at delivery	<input type="checkbox"/> <input type="checkbox"/>	Mode of delivery	<input type="checkbox"/>	spontaneous <input type="checkbox"/>	as- <input type="checkbox"/> c-section
				sisted	
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"/>	No <input type="checkbox"/>			
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					

Muscle hematomas					No <input type="checkbox"/>	Yes <input type="checkbox"/>
Total #					<input type="text"/>	
MOST SEVERE PRESENTATION						
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"/>				
		Replacement therapy <input type="checkbox"/>			Blood transfusion <input type="checkbox"/>	
Notes						

Hemarthrosis					No <input type="checkbox"/>	Yes <input type="checkbox"/>
Total #					<input type="text"/>	
MOST SEVERE PRESENTATION						
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						

CNS bleeding	No <input type="checkbox"/>	Yes <input type="checkbox"/>
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If yes, type of bleeding

Subdural, any intervention ☐ Intracerebral, any inter-
vention ☐

Other bleeding	No <input type="checkbox"/>	Yes <input type="checkbox"/>
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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"/>
	Suction Bleeding <input type="checkbox"/>	Hematuria, macroscopic	

MOST SEVERE PRESENTATION

Please specify type

Required medical attention?	Yes <input type="checkbox"/>
No <input type="checkbox"/>	

If yes, please specify:

<input type="checkbox"/> Consultation only	Iron Therapy
<input type="checkbox"/> Surgical Hemostasis	<input type="checkbox"/> Antifibrinolytics
<input type="checkbox"/> Antifibrinolytics	<input type="checkbox"/> Desmopressin
<input type="checkbox"/> Replacement therapy	<input type="checkbox"/> Blood transfusion

Notes

Other bleeding continued

MOST SEVERE PRESENTATION

Please specify type

Required medical attention?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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If yes, please specify:

<input type="checkbox"/> Consultation only	Iron Therapy
<input type="checkbox"/> Surgical Hemostasis	<input type="checkbox"/> Antifibrinolytics
<input type="checkbox"/> Antifibrinolytics	<input type="checkbox"/> Desmopressin
<input type="checkbox"/> Replacement therapy	<input type="checkbox"/> Blood transfusion

Notes

Other bleeding continued

MOST SEVERE PRESENTATION

Please specify type

Required medical attention?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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If yes, please specify:

<input type="checkbox"/> Consultation only	Iron Therapy
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- | | |
|--|--|
| <input type="checkbox"/> Surgical Hemostasis | <input type="checkbox"/> Antifibrinolytics |
| <input type="checkbox"/> Antifibrinolytics | <input type="checkbox"/> Desmopressin |
| <input type="checkbox"/> Replacement therapy | <input type="checkbox"/> Blood transfusion |

Notes

Score Symptom	-1	0	1	2	3	4
Epistaxis	-	No or trivial (≤ 5 per year)	>5 per year OR >10 minutes duration	Consultation only	Packing, cauterization or antifibrinolytics	Blood transfusion, replacement therapy or desmopressin
Cutaneous	-	No or trivial (≤ 1 cm)	>1 cm AND no trauma	Consultation only	-	-
Minor wounds	-	No or trivial (≤ 5 per year)	>5 per year OR >5 minutes duration	Consultation only or Steri-strips	Surgical hemostasis or antifibrinolytics	Blood transfusion, replacement therapy or desmopressin
Oral cavity	-	No	Reported at least once	Consultation only	Surgical hemostasis or antifibrinolytics	Blood transfusion, replacement therapy or desmopressin
Gastrointestinal tract	-	No	Identified cause	Consultation or spontaneous	Surgical hemostasis, antifibrinolytics, blood transfusion, replacement therapy or desmopressin	-
Tooth extraction	No bleeding in at least 2 extractions	None done or no bleeding in 1 extraction	Reported, no consultation	Consultation only	Resuturing, repacking or antifibrinolytics	Blood transfusion, replacement therapy or desmopressin
Surgery	No bleeding in at least 2 surgeries	None done or no bleeding in 1	Reported, no consultation	Consultation only	Surgical hemostasis or antifibrinolytics	Blood transfusion, replacement therapy or desmopressin
Menorrhagia	-	No	Reported or consultation only	Antifibrinolytics or contraceptive pill use	D&C or iron therapy	Blood transfusion, replacement therapy, desmopressin or hysterectomy
Post-partum	No bleeding in at least 2 deliveries	No deliveries or no bleeding in 1 delivery	Reported or consultation only	D&C, iron therapy or antifibrinolytics	Blood transfusion, replacement therapy or desmopressin	-
Muscle hematoma	-	Never	Post-trauma, no therapy	Spontaneous, no therapy	Spontaneous or traumatic, requiring replacement therapy or desmopressin	Spontaneous or traumatic, requiring surgical intervention or blood transfusion
Hemarthrosis	-	Never	Post-trauma, no therapy	Spontaneous, no therapy	Spontaneous or traumatic, requiring replacement therapy or desmopressin	Spontaneous or traumatic, requiring surgical intervention or blood transfusion
Central nervous system	-	Never	-	-	Subdural, any intervention	Intracerebral, any intervention
Other *	-	No	Reported	Consultation only	Surgical hemostasis, antifibrinolytics or iron therapy	Blood transfusion, replacement therapy or desmopressin

Table shows the scoring key for the Pediatric Bleeding Questionnaire. In the last row, the symptoms included in the “Other” category are: umbilical stump bleeding, cephalohematoma, post-circumcision bleeding, post-venipuncture bleeding, and macroscopic hematuria.