PENTA

Pediatric Ear, Nose & Throat of Atlanta, P.C.

BLEEDING HISTORY QUESTIONNAIRE FORM

Putting Your Child First

404.255.2033

CHECK the appropriate YES or NO box

A. PERSONAL HISTORY:

1. Has your child ever had surgery, stitches for trauma or a broken bone? ☐ Y ☐ N

   If YES, did your child experience bleeding during or after the procedure? ☐ Y ☐ N

   What was the procedure? _____

2. Does your child bruise easily compared to normal? ☐ Y ☐ N
3. If a boy, did your child bleed after circumcision? ☐ Y ☐ N
4. Did he/she bleed after the umbilical cord came off? ☐ Y ☐ N
5. Has your child had frequent nosebleeds? ☐ Y ☐ N
6. Has your child bled after tooth extractions, wisdom tooth surgery or with the loss of baby teeth? ☐ Y ☐ N
7. Is your child taking any of the following:

   aspirin ☐ Y ☐ N

   ibuprofen products ☐ Y ☐ N

   antihistamines ☐ Y ☐ N
8. Is there any history of heavy menstrual periods? ☐ Y ☐ N

B. FAMILY HISTORY

1. Are there women in your family (mother, aunt, sister, grandmother) who have had monthly periods requiring either iron therapy or transfusions? ☐ Y ☐ N
2. Is there anyone in the family with a history of frequent nosebleeds judged to be severe or requiring a blood transfusion? ☐ Y ☐ N
3. Is there anyone in your family who bled after tooth extractions, wisdom tooth surgery or loss of baby teeth? ☐ Y ☐ N
4. Has anyone in the family required a blood transfusion? ☐ Y ☐ N

Who? _____

Reason for transfusion? _____

5. Has anyone in the family been called a free bleeder? ☐ Y ☐ N
6. Has anyone in your family ever bled after tonsil surgery, childbirth, or other operations? ☐ Y ☐ N
7. Is there anyone in the family with hemophilia, Von Willebrand disease, low platelets or ITP (Idiopathic thrombocytopenia purpura)? ☐ Y ☐ N

   Who? _____

   Diagnosis _____

RESET FORM