
















# Celiac Disease Symptom Survey



Use this survey to help you talk about your symptoms with your doctor. Remember, one symptom doesn't define celiac disease. But one test can.

1. Do you have any of the common symptoms of celiac disease listed below? (Choose all that apply.)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/>  Bloating         | <input type="checkbox"/>  Fatigue     | <input type="checkbox"/>  Irritability              |
| <input type="checkbox"/>  Constipation     | <input type="checkbox"/>  Gas         | <input type="checkbox"/>  Itchy Skin Rash           |
| <input type="checkbox"/>  Depression       | <input type="checkbox"/>  Headaches   | <input type="checkbox"/>  Mouth Sores               |
| <input type="checkbox"/>  Diarrhea         | <input type="checkbox"/>  Heartburn   | <input type="checkbox"/>  Stomach Pain              |
| <input type="checkbox"/>  Discolored Teeth | <input type="checkbox"/>  Infertility | <input type="checkbox"/>  Thin Bones (osteoporosis) |

2. Do you have any first-degree relatives with celiac disease? (Check all that apply.)

- |                                 |                                  |                                |
|---------------------------------|----------------------------------|--------------------------------|
| <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling | <input type="checkbox"/> Child |
|---------------------------------|----------------------------------|--------------------------------|

3. Do you have any second-degree relatives with celiac disease? (Check all that apply.)

- |  |                                      |                                     |  |                                 |                                       |
|--|--------------------------------------|-------------------------------------|--|---------------------------------|---------------------------------------|
| <input type="checkbox"/> Aunt or uncle | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Grandchild | <input type="checkbox"/> Niece or nephew | <input type="checkbox"/> Cousin | <input type="checkbox"/> Half-sibling |
|--|--------------------------------------|-------------------------------------|--|---------------------------------|---------------------------------------|

4. Have you had any of the following?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Iron deficiency                      | <input type="checkbox"/> Miscarriage(s)                                 | <input type="checkbox"/> Malnutrition                         |
| <input type="checkbox"/> Lack of muscle coordination (ataxia) | <input type="checkbox"/> Short stature (child)                          | <input type="checkbox"/> Weight loss or gain (unexplained)    |
| <input type="checkbox"/> Failure to thrive                    | <input type="checkbox"/> A delay in development (child)                 | <input type="checkbox"/> Unexplained problems with your liver |
| <input type="checkbox"/> Vomiting                             | <input type="checkbox"/> Seizures                                       | <input type="checkbox"/> Late puberty                         |
|   | <input type="checkbox"/> Loss of hair from your head or body (alopecia) |   |

5. Do you have any of the following conditions?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Sjögren's syndrome   | <input type="checkbox"/> Turner syndrome                |
| <input type="checkbox"/> Juvenile idiopathic arthritis | <input type="checkbox"/> IBS (irritable bowel syndrome)                                 | <input type="checkbox"/> Williams syndrome              |
| <input type="checkbox"/> Type 1 diabetes               | <input type="checkbox"/> Numbness or pain in the hands and feet (peripheral neuropathy) | <input type="checkbox"/> Low levels of immunoglobulin A |
| <input type="checkbox"/> Thyroid disease               | <input type="checkbox"/> Down syndrome  | <input type="checkbox"/> Cancer                         |