

# Stanford Celiac Sprue Management Clinic History Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: M F

1. How were you diagnosed with Celiac Sprue? (Check all that apply)

Analysis of small intestinal biopsy (from the duodenum or jejunum)

Positive endomysial antibody (EMA)

Positive transglutaminase antibody (TTG)

Positive anti-gliadin antibody (AGA)

Abnormal xylose absorption test

Increase in fat in stool collection

Response to a gluten-exclusion diet

HLA typing: HLA DQ2 HLA DQ8

Skin biopsy characteristic of Dermatitis Herpetiformis

Other: \_\_\_\_\_

2. When were you diagnosed? (Write in month and year if possible) \_\_\_\_\_

3. Age at diagnosis? \_\_\_\_\_

4. If you were diagnosed by biopsy, have you had a follow-up biopsy? \_\_\_\_\_ If so,  
when and what did it show? \_\_\_\_\_  
\_\_\_\_\_

5. Have you had follow-up antibody tests? \_\_\_\_\_ If so, how recently? \_\_\_\_\_

6. Did you see a dietician upon being diagnosed with Celiac Sprue? \_\_\_\_\_

7. Does anyone in your family have Celiac Sprue? \_\_\_\_\_ If yes, give  
relationship \_\_\_\_\_

8. What is your current treatment? (Check all that apply)

Gluten-exclusion diet

Corticosteroids (e.g. Prednisone, Decadron)

Sulfasalazine, Asacol, Pentasa, or other 5-aminosalicylic acid drugs

Other: \_\_\_\_\_

9. When was the last time you had an appointment with a physician for follow-up of  
Celiac Sprue? \_\_\_\_\_

10. Do you belong to a Celiac Support Group? \_\_\_\_\_

11. When did your symptoms of Celiac Sprue begin? \_\_\_\_\_

12. Have you experienced any of the following symptoms? (Check all that apply)

**At diagnosis In the past month**

- More than 3 stools per day
- Loose/watery stools
- Foul smelling, oily, or poorly flushing stool
- Abdominal bloating after meals
- Excessive gas passage
- Rapid filling after small meals
- Fatigue or weakness
- Unintentional weight loss
- Abdominal discomfort/pain
- Nausea with or without vomiting
- Mouth sores
- Muscle or joint pain
- Skin rashes
- No symptoms
- Other: \_\_\_\_\_

13. How often do you experience symptoms that you believe are due to gluten-contamination?

- |                      |                       |                  |
|----------------------|-----------------------|------------------|
| Every day            | Several times a month | 1-2 times a year |
| Several times a week | Once a month          | Never            |
| Once a week          | 3-4 times a year      |                  |

14. How often do you eat outside the home? (e.g. restaurants, friends' houses, etc.)

- |                      |                       |                  |
|----------------------|-----------------------|------------------|
| Every day            | Several times a month | 1-2 times a year |
| Several times a week | Once a month          | Never            |
| Once a week          | 3-4 times a year      |                  |

15. Do you eat oats/oat-containing products? \_\_\_\_\_

16. Have you been diagnosed with or experienced any of the following diseases or conditions?

- |                                      |                            |
|--------------------------------------|----------------------------|
| Anemia                               | Lactose intolerance        |
| Anxiety                              | Liver disease              |
| Blood clotting problems              | Miscarriages               |
| Cancer of the gastrointestinal tract | Neurologic problems        |
| Depression                           | Osteopenia or Osteoporosis |
| Dermatitis herpetiformis             | Rheumatoid arthritis       |
| Diabetes (insulin-dependent)         | Short stature              |
| IgA deficiency                       | Sjogren's Syndrome         |
| Infertility                          | Thyroid disease            |

If you checked any of the above, please explain. \_\_\_\_\_

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17. Please list any other medical problems. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. Please list any medications that you take (prescribed or over-the-counter) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

19. Please list any medication allergies? \_\_\_\_\_

20. Do you have any food allergies/intolerances (other than gluten)? \_\_\_\_\_ If so,  
list the foods and the symptoms that may cause. \_\_\_\_\_  
\_\_\_\_\_