



**WM. K. WARREN
MEDICAL RESEARCH CENTER
FOR CELIAC DISEASE**

Application for Celiac Disease Screening Program

APPLICANT INFORMATION [please print]

Today's Date: _____

Name: _____

Date of Birth: _____

Email address: _____

Gender: Male Female

Home Address: _____

Telephone #(s): _____ Type: Home Cell Work

_____ Type: Home Cell Work

How did you hear about the Warren Celiac Center screening program?

Please provide a reason for why you want to be screened for Celiac Disease.

HISTORY

Have you ever been screened with a blood test for celiac disease in the past? Yes No

If yes, when were you last tested for celiac disease? _____

Before seeing the advertisement for this study, did you know what celiac disease is? Yes No

Before seeing the advertisement for this study, did you know that you might be at risk for celiac disease? Yes No

Have you had difficulty getting screened for celiac disease? Yes No

RISK FACTORS (check all that apply to you):

I have a family member with celiac disease.
If yes, please provide relationship (i.e. father, mother, sister, brother, uncle, etc): _____

I have gastrointestinal complaints for more than four weeks that has affected my quality of life, such as abdominal pain, bloating/gas, diarrhea, constipation, or unexplained weight loss.
If yes, please specify most bothersome symptom(s) _____

I have non-gastrointestinal complaints associated with celiac disease such as (check all that apply):

- | | |
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| <input type="checkbox"/> Sjögren's Syndrome | <input type="checkbox"/> Autoimmune thyroid disease |
| <input type="checkbox"/> Type I Diabetes Mellitus | <input type="checkbox"/> Iron deficiency or anemia where the cause is unknown |
| <input type="checkbox"/> Unexplained Infertility/miscarriages | <input type="checkbox"/> Dermatitis Herpetiformis (a blistering, itchy skin rash) |
| <input type="checkbox"/> Osteoporosis or bone disease. If yes, please provide age at diagnosis _____ | |
| <input type="checkbox"/> Liver disease, either autoimmune or primary biliary cirrhosis or unexplained cause for abnormal liver tests | |

DIRECTIONS

Return completed application by **JUST ONE** of the following methods

<p>EMAIL Send as an e-mail attachment to celiaccenter@ucsd.edu (Please change filename to include your last name.)</p>	<p>FAX Send to (858) 534-5691 (A cover sheet is not necessary.)</p>	<p>REGULAR MAIL- Send to: UCSD - Warren Celiac Center Attn: Screening Program 9500 Gilman Drive, MC0623D La Jolla, CA 92093-0623</p>
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