

# THE KOGAN CELIAC CENTER

## Screening Form

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Home phone:** \_\_\_\_\_ **Cell phone:** \_\_\_\_\_

**How did you hear about this screening?** \_\_\_\_\_

Please review the list of possible risk factors for Celiac Disease listed below.

**Please check off any of these that apply to you:**

- You have a mother, father, sister, brother, daughter or son with Celiac Disease
- You have an aunt, uncle or grandparent with Celiac Disease
- Dermatologic conditions including Alopecia and Vitiligo (please specify)

**Autoimmune disorders:**

- Type 1 Diabetes – yourself or immediate family member (please specify)*

*Thyroiditis*

*Addison’s Disease*

*Primary Biliary Cirrhosis*

*Autoimmune Hepatitis*

*Rheumatoid Arthritis*

*Sjogren’s Syndrome*

*Frequent Infections*

Iron-Deficiency Anemia

*(that has not responded to iron therapy)*

Dental Enamel Hypoplasia

Osteopenia/Osteoporosis

Unexplained Infertility/Miscarriage/Missed Menstrual Periods

Persistent GI symptoms i.e., Irritable Bowel Syndrome *(diarrhea, constipation, bloating, gas, abdominal pain, weight loss)*

Down Syndrome

Turner’s Syndrome

Williams Syndrome

Current or past childhood history of growth problems, underweight or failure to thrive

**If you checked off any of the above conditions or items, we invite you to attend our next Celiac Screening.**

**Registration is required. For more information and to register, please call 1.888.SBHS.123 (1.888.724.7123).**

**For your reference when you register:**

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Place:** \_\_\_\_\_

Located at: Saint Barnabas Ambulatory Care Center  
200 South Orange Avenue  
Livingston, New Jersey 07039

