

SHORT GLUTEN SENSITIVITY QUESTIONNAIRE

By James Braly, MD

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Name: _____ Date: _____

Age: _____ Sex: _____ Weight: _____ Height: _____

Address: _____

Phone #: _____ E-mail: _____

Current Medical Conditions: _____

| | | |
|---|--|--|
| 1 | Do members of your family suffer from a sensitivity to wheat or gluten? ____ Yes ____ No | |
| 2 | Do you suffer from long-term depression for no apparent reason? ____ Yes ____ No | |
| 3 | Do you suffer from recurring stomach aches, bloating, or excess gas for no apparent reason? ____ Yes ____ No | |
| 4 | Do you have a recent history of iron deficiency or liver disease for no apparent reason? ____ Yes ____ No | |
| 5 | Do you suffer from insulin-dependent diabetes and/or thyroid disease? ____ Yes ____ No | |
| 6 | Do you suffer from recurring mouth ulcers, canker sores, or enamel defects for no apparent reason? ____ Yes ____ No | |