



## Candida Questionnaire and Score Sheet

This questionnaire is designed for adults and the scoring system isn't appropriate for children. It lists factors in your medical history that promote the growth of *Candida albicans* (Section A), and symptoms commonly found in individuals with yeast-connected illness (Sections B and C).

For each "Yes" answer in Section A, check the point score in the box at the end of the section. Then move onto Sections B and C and score as directed.

Filling out and scoring the questionnaire should help you and your doctor evaluate the possible role of candida in contributing to your health problems. Yet, it will not provide an automatic "Yes" or "No" answer.

### SECTION A: HISTORY

- 1. Have you taken Tetracyclines (Sumycin™, Panmycin™, Vibramycin™, Minocin™, etc.) or other antibiotics for acne for one month or longer?  25
- 2. Have you, at any time in your life, taken other "broad spectrum" antibiotics\* for respiratory, urinary, or other infections for 2 months or longer or in shorter courses 4 or more times in a 1-year period?  20
- 3. Have you taken a broad spectrum antibiotic\*--even in a single course?  6
- 4. Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis, or other problems affecting your reproductive organs?  25
- 5. Have you been pregnant
  - 2 or more times?.....  5
  - 1 time?.....  3
- 6. Have you taken birth control pills
  - For more than 2 years?.....  15
  - For 6 months to 2 years?.....  8
- 7. Have you taken prednisone, Decadron or other cortisone-type drugs, by injection or inhalation
  - For more than 2 weeks?.....  15
  - For 2 weeks or less?.....  6
- 8. Does exposure to perfumes, insecticides, fabric shop odors and other chemicals provoke
  - Moderate to severe symptoms?.....  20
  - Mild symptoms?.....  5
- 9. Are your symptoms worse on damp, muggy days or in moldy places?  20
- 10. Have you had athlete's foot, ringworm, jock itch or other chronic fungus infections of the skin or nails? Have such infections been
  - Severe or persistent?.....  20
  - Mild to moderate?.....  10
- 11. Do you crave sugar?  10



- 12. Do you crave breads?  10
- 13. Do you crave alcoholic beverages?  10
- 14. Does tobacco smoke really bother you?  10

Total Score, Section A: \_\_\_\_\_

\* Including Kelex, ampicillin, amoxicillin, Ceclor, Bactrim, and Septra. Such antibiotics kill off "good germs" while they are killing off those which cause infection.

**SECTION B: HISTORY**

For each of your symptoms, check the number in the appropriate column.

	Not at all	Occasional or mild	Frequent and/or moderately severe	Severe and/or disabling
Fatigue or lethargy	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Feeling of being "drained"	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Poor memory or concentration	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Feeling "spacey" or "unreal"	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Depression	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Numbness, burning, or tingling	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Muscle aches	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Muscle weakness or paralysis	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Pain and/or swelling in joints	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Abdominal pain	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Constipation	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Diarrhea	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Bloating	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Troublesome vaginal discharge	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Persistent vaginal burning or itching	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Prostatitis	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Impotence	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Loss of sexual desire	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Endometriosis or infertility	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Cramps and/or other menstrual irregularities	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Premenstrual tension	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Spots in front of the eyes	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
Erratic vision	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9

Total Score, Section B: \_\_\_\_\_



**SECTION C: OTHER SYMPTOMS**

	Not at all	Occasional or mild	Frequent and/or moderately severe	Severe and/or disabling
Drowsiness	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Irritability or jitteriness	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Incoordination	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Inability to concentrate	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Frequent mood swings	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Headache	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Dizziness/loss of balance	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Pressure above ears, feeling of head swelling and tingling	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Itching	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Other rashes	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Heartburn	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Indigestion	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Belching and intestinal gas	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Mucus in stools	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Hemorrhoids	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Dry mouth	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Rash or blisters in mouth	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Bad breath	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Joint swelling or arthritis	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Nasal congestion or discharge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Postnasal drip	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Nasal itching	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sore or dry throat	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Cough	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Pain or tightness in chest	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Wheezing or shortness of breath	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Urinary urgency or frequency	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Burning on urination	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Failing vision	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Burning or tearing of eyes	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Recurrent infections or fluid in ears	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Ear pain or deafness	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Total Score, Section C: \_\_\_\_\_  
 Total Score, Section A: \_\_\_\_\_  
 Total Score, Section B: \_\_\_\_\_  
 Grand Score: \_\_\_\_\_



The Grand Total Score will help you and your doctor decide if your health problems are yeast-connected. Scores in women will run higher as 7 items in the questionnaire apply exclusively to women, while only 2 apply exclusively to men.

## INTERPRETATION

	<i>Women</i>	<i>Men</i>
Yeast-connected health problems are almost certainly present	>180	>140
Yeast-connected health problems are probably present	120-180	90-140
Yeast-connected health problems are possibly present	60-119	40-89
Yeast-connected health problems are not likely present	<60	<40

## DISCLAIMER

The nutritional suggestions in this material are not offered to treat, mitigate or cure disease, and should not be used as a substitute for sound medical advice. This information is designed to be used in conjunction with the services of a trained, licensed healthcare practitioner.