YEAST OVERGROWTH QUESTIONNAIRE

Name______________________________ Date______________

Choose the score that fits your symptom best and circle it.

SECTION A. MAJOR SYMPTOMS

Scoring: None = 0 Mild = 4 Moderate = 8 Severe = 12

Energy/Toxicity:

0 4 8 12 Fatigue or lethargy
0 4 8 12 Irritable or uncomfortable when hungry
0 4 8 12 Headache

Mental / Emotional functioning:

0 4 8 12 Anxiety, sometimes without apparent cause
0 4 8 12 Depression
0 4 8 12 Feel spacey, light-headed, or disoriented
0 4 8 12 Poor memory
0 4 8 12 Inability to make decisions and to concentrate

Digestive symptoms:

0 4 8 12 Bloating or gas
0 4 8 12 Chronic diarrhea
0 4 8 12 Chronic constipation
0 4 8 12 Abdominal pain

Reproductive system:

0 4 8 12 Loss of sexual interest or ability
0 4 8 12 Troublesome vaginal burning, itching, or discharge
0 4 8 12 Premenstrual tension or cramps

Muscles and joints:

0 4 8 12 Muscle aches and weakness
0 4 8 12 Cold hands or feet or physical chilliness
0 4 8 12 Pain or swelling in joints

TOTAL, SECTION A ____

SECTION B. OTHER SYMPTOMS

Scoring: None = 0 Mild = 3 Moderate = 6 Severe = 9

0 3 6 9 Chronic eczema, rashes, or itching
0 3 6 9 Body odor not relieved by washing or bad breath
0 3 6 9 Chronic sore throat, laryngitis, cough, or tender glands
0 3 6 9 Urinary frequency, burning or urgency
0 3 6 9 Pain or tightness in chest, wheezing, or shortness of breath
0 3 6 9 Recurrent ear infections, fluid in ears, or nasal congestion
0 3 6 9 Tendency to bruise easily
0 3 6 9 Chronic sinus infections
0 3 6 9 Lack of coordination, dizziness, or poor balance
0 3 6 9 Itching û vaginal, anal or other
0 3 6 9 Food sensitivity or intolerance

TOTAL, SECTION B ____

SECTION C. MAJOR INFLUENCES - PERSONAL HISTORY

No Yes **Scoring: No=0 Yes=number indicated**

0 35 Have you taken tetracycline or other antibiotics for one month or longer?
0 35 Taken frequent short courses of other broad-spectrum antibiotics?
0 15 Taken prednisone or other cortisone-type drugs for one month or more?
0 10 Taken birth control pills for more than a year?
0 25 Have you had persistent yeast infections, prostatitis, vaginitis, other reproductive problems, or bladder infections?
0 20 Been frequently exposed to high mold environments and seem to have a sensitivity to mold?
0 20 Severe athlete's foot, nail or skin fungus, ring worm, or other chronic fungus?
0 10 Have you been treated for internal parasites?
0 20 Does exposure to perfumes, insecticides, or other chemicals provoke noticeable symptoms?
0 10 Does tobacco smoke *really* bother you?
0 10 Do you crave or consume lots of sweets?
0 10 Do you crave or eat lots of starches such as pastas or breads?
0 10 Do you crave or consume alcoholic beverages?

TOTAL, SECTION C ____

GRAND TOTAL, SECTIONS A, B, & C ____

***Finally,** when was your last exposure to cortisone, antibiotics, or birth control pills?______________

Scores over 100 suggest the possibility of a candida overgrowth; over 175 indicates a high probability.