Candida Yeast Questionnaire

This questionnaire is designed for adults. It lists factors in your medical history that promote the growth of Candida albicans yeast and symptoms commonly found when yeast is present in excessive amounts in the body. All of these symptoms have other possible causes. However, filling out and scoring this questionnaire will help you and your practitioner evaluate the possible role of yeast overgrowth in contributing to your health problems.

Section A: History and Current Major Symptoms **Point Score**

For each "yes" answer, circle the point score. Total your score and record it at the end of the questionnaire.

History

1. Have you ever taken tetracycline or another antibiotic for one month or longer? 25

2. Have you ever taken other "broad spectrum" antibiotics for respiratory, urinary or other infections for more than two months at a time? Or did you take several shorter courses of antibiotics within a one-year period? 20

3. Have you ever taken even a single course of any antibiotics? 6

4. Have you ever been bothered by persistent prostatitis, vaginitis or other problems affecting your reproductive organs? 25

5. Have you ever been pregnant?
   - Two or more times 5
   - One time 3

6. Have you ever taken birth control pills?
   - For more than two years 15
   - For six months to two years 8

7. Have you ever taken prednisone, Decadron, steroid nasal sprays or other cortisone-type drugs?
   - For more than 2 weeks 15
   - For less than 2 weeks 6

8. Does exposure to perfume, insecticides, fabric shop odors and other chemicals provoke symptoms?
   - Moderate to severe symptoms 20
   - Mild symptoms 5

9. Are any of your symptoms worse on damp, muggy days, or in damp or moldy places? 20

10. Have you ever had athlete's foot, ring worm, jock itch or other chronic fungus infection of the skin or nails?
    - If so, have these infections been severe or persistent? 20
    - If so, have these infections been only mild or moderate? 10

Current Major Symptoms

11. Do you especially like sugar or want to eat sweets daily? 10

12. Do you especially like bread or regularly eat multiple portions of bread items? 10

13. Do you especially like alcoholic beverages or drink several times a week? 10

14. Does tobacco smoke really bother you? 10

Total Score, Section A _____

Name _____ Date _____

Sections B and C: Recent or Current Symptoms

For each these, enter the appropriate number in the Point Score column. Leave the space blank if you don't have that symptom.

Section B: Recent/Current Symptoms

3 points if a symptom is occasional or mild.
6 points if a symptom is frequent or moderately severe.
9 points if a symptom is severe or disabling.

1. Fatigue or lethargy _____
2. Feeling of being drained _____
3. Poor memory _____
4. Feeling spacey or unreal _____
5. Depression _____
6. Numbness, burning or tingling _____
7. Muscle aches _____
8. Muscle weakness or paralysis _____
9. Pain and/or swelling in joints _____
10. Abdominal pain _____
11. Constipation _____
12. Diarrhea _____
13. Bloating _____
14. Troublesome vaginal discharge _____
15. Persistent vaginal burning or itching _____
16. Prostatitis (inflammation of prostate) _____
17. Impotence (men) _____
18. Loss of sexual desire _____
19. Endometriosis _____
20. Cramps or other menstrual irregularities _____
21. Premenstrual tension _____
22. Spots in front of eyes _____
23. Erratic vision

Total Score, Section B _____

Section C: Recent/Current Symptoms

1 point if a symptom is occasional or mild.
2 points if a symptom is frequent or moderately severe.
3 points if a symptom is severe or disabling.

1. Drowsiness _____
2. Irritability _____
3. Lack of coordination _____
4. Inability to concentrate _____
5. Frequent mood swings _____
6. Headache _____
7. Dizziness or loss of balance _____
8. Pressure feeling above ears _____
9. Head swelling or tingling _____
10. Itching _____
11. Rashes _____
12. Heartburn _____
13. Indigestion _____
14. Belching and intestinal gas _____
15. Mucous in the stools _____
16. Hemorrhoids _____
17. Dry mouth _____
18. Rash or blisters in mouth _____
19. Bad breath _____
20. Joint swelling or arthritis _____
21. Postnasal drip _____
22. Sore or dry throat _____
23. Cough _____
24. Pain or tightness in chest _____
25. Wheezing or shortness of breath _____
26. Urinary urgency or frequency _____
27. Burning on urination _____
28. Failing vision _____
29. Eyes burning or tearing _____
30. Recurrent infections _____
31. Ear pain or deafness _____

Total Score, Section C _____
Total Score, Section B _____
Total Score, Section A _____

Grand Total Score _____

The Grand Total Score will help you and your practitioner decide if your health problems may be connected to yeast overgrowth. Note: if you have high pain tolerance, you may have yeast overgrowth even if your score is lower than the high and middle ranges below.

Women's Scores

Over 180 = yeast overgrowth almost certainly present
Over 120 = yeast overgrowth probably present
Less than 60 = the risk of yeast overgrowth is low

Men's Scores

Over 140 = yeast overgrowth almost certainly present
Over 90 = yeast overgrowth probably present
Less than 40 = the risk of yeast overgrowth is low

This questionnaire is based on the original Candida questionnaire taken from The Yeast Connection by William Crook, M.D.