

Candida Questionnaire

Name _____ Date _____

Are your problems yeast connected? **Yes** **No**

Have you taken repeated antibiotic drugs?		
Have you been troubled by premenstrual tension, abdominal pain, menstrual problems, vaginitis, prostatitis or loss of sexual interest?		
Does exposure to tobacco, perfume or other chemical odors provoke moderate to severe symptoms?		
Do you crave sugar, breads or alcoholic beverages?		
Are you bothered by recurrent digestive problems?		
Are you bothered by fatigue or depression symptoms?		
Are you bothered by hives, psoriasis or other chronic skin rashes?		
Have you ever taken birth control pills?		
Are you bothered by headaches, muscle and joint pains, or lack of coordination of movement?		
Do you feel bad all over, yet no cause has been found?		

If you answered "yes" 3-4 times, yeasts probably plays a role in your illness.

If you answered "yes" 5-7 times, yeasts probably cause your symptoms.

If you answered "yes" more than 8 times, yeasts are almost certainly involved your illness.

Section A: History

If your answer is "yes" to any of the questions in this section, write in the number of points in parenthesis in the score column. **Score**

Have you ever taken antibiotics for a month or more? (35) _____

Have you at any time in your life taken "broad spectrum" antibiotics for respiratory, urinary or other infections (for two months or longer, or in shorter courses four or more times in a year)? (35) _____

Have you ever taken a "broad spectrum" antibiotic drug—even a single dose course? (6) _____

Have you, at any time in your life, been bothered by persistent prostates, vaginitis or other problems affecting reproductive organs? (25) _____

Have you been pregnant two or more times? (5) _____

One pregnancy? (3) _____

Have you taken Prednisone, Decadron or other cortisone-type drug for more than two weeks? (15)
Two weeks or less? (6) _____

Have you taken birth control pills for more than two years? (15) For more than six months and up to two years? (8) _____

Does exposure to perfumes, insecticides, fabric shop odors and other chemicals provoke moderate to severe symptoms? (20) Mild symptoms? (5) _____

Are your symptoms worse on damp, muggy days or in moldy places? (20) _____

Have you had Athlete's foot, ring worm, "jock itch" or other chronic fungal infections of the skin and nails? Have such infections been severe or persistent? (20) Mild to moderate? (10) _____

Do you crave sugar or sweet foods? (10) _____

Do you crave breads? (10) _____

Do you crave alcoholic beverages? (10) _____

Does tobacco smoke really bother you? (10) _____

Total score from section A (Max. 278)

Section B: Major Symptoms

If a symptom is **occasional** or **mild**, score 3 points

If a symptom is **frequent** or **moderately severe**, score 6 points

If a symptom is **severe** and/or **disabling**, score 9 points

- | | Score |
|--------------------------------------|--------------|
| ■ fatigue or lethargy | _____ |
| ■ feeling of being "drained" | _____ |
| ■ poor memory | _____ |
| ■ feeling "spacey" or "unreal" | _____ |
| ■ depression | _____ |
| ■ numbness | _____ |
| ■ muscle aches | _____ |
| ■ muscle weakness or paralysis | _____ |
| ■ pain and/or swelling in the joints | _____ |
| ■ abdominal pain | _____ |
| ■ constipation | _____ |
| ■ diarrhea | _____ |
| ■ bloating | _____ |

- troublesome vaginal discharge _____
- persistent vaginal burning or itching _____
- prostatitis _____
- impotence _____
- loss of sexual desire _____
- cramps and/or other menstrual irregularities _____
- premenstrual tension _____
- spots in front of eyes _____
- erratic vision _____

Total score from section B (Max. 207)

Section C: Other Symptoms

If a symptom is **occasional** or **mild**, score 1 point

If a symptom is **frequent** or **moderately severe**, score 2 points

If a symptom is **severe** and/or **disabling**, score 3 points

- | | Score |
|--|--------------|
| ■ drowsiness | _____ |
| ■ lack of coordination | _____ |
| ■ irritability or jitteriness | _____ |
| ■ frequent mood swings | _____ |
| ■ dizziness loss of balance | _____ |
| ■ pressure above ears, feeling head swelling or tingling | _____ |
| ■ itching | _____ |
| ■ other rashes | _____ |
| ■ heartburn | _____ |
| ■ indigestion | _____ |
| ■ belching and intestinal gas | _____ |
| ■ mucous in stools | _____ |
| ■ hemorrhoids | _____ |

- dry mouth _____
- rash or blisters in the mouth _____
- bad breath _____
- joint swelling or arthritis _____
- nasal congestion _____
- post nasal drip _____
- nasal itching _____
- sore or dry throat _____
- cough _____
- pain or tightness in chest _____
- wheezing or shortness of breath _____
- urgency or urinary frequency _____
- burning during urination _____
- burning or watery eyes _____
- failing vision _____
- recurrent infections or fluid in the ears _____
- ear pain or deafness _____

Total score from section C (Max. 96)

Total score from section A _____

Total score from section B _____

Total score from section C _____

Grand total _____ **/581**

Signature _____

Date _____

Please return to: loracantele@gmail.com or mail to the address below

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