YEAST QUESTIONNAIRE

Symptoms Questionnaire and Score Sheet

(Don't forget to bring the completed form with you to your next appointment)

Name_____

Age _____

Answering these questions and adding up the scores will help you and your doctor decide if yeast is likely to be contributing to your health problems. Add the total of your scores to get your Grand Total Score.

SECTION A: History

For each "Yes" answer in Section A circle the Point Score in that section. Total the score and record it in the box at the end of Section A.

Question	Point Score
1. Have you ever taken tetracycline (Symycin®, Vibramycin®, etc.) or other antibiotics for acne one month or longer?	**35**
2. Have you, at any time in your life, taken other "broad-spectrum" antibiotics for respiratory, urinary, or other infections for two months or longer or in shorter courses four ot times in a one year period?	**35**
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: Two or more times? One time?	 **5** **3**
6. Have you taken birth control pills: More than two years? Six months to two years?	 **15** **8**
7. Have you taken Prednisone®, Decadron®, or other cortisone-type drugs: More than two years? Six months to two years?	 **15** **6**
8. Does exposure to perfumes, insecticides, fabric shop odors, and other chemicals Provoke? Moderate to severe symptoms? Mild symptoms	 **20** **5**
9. Are your symptoms worse on damp, muggy days or in moldy places?	**20**
10. Have you had athlete's foot, ring worm, jock itch or other chronic fungus infections of skin or nails: More than two years? Six months to two years?	 **20** **10**
11. Do you crave sugar?	**10**
12. Do you crave bread?	**10**
13. Do you crave alcoholic beverages	**10**
14. Does tobacco smoke really bother you?	**10**
TOTAL SCORE, SECTION A	

SECTION B: Major Symptoms
For each of your symptoms, circle the appropriate figure in the point score column:
Occasional or mild.....3 points
Frequent and/or moderately severe .....6 points
Severe and/or disabling.....9 points
Add the points and record your total score for Section B in the Total Score, Section B box.

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

SECTION C: Other Symptoms
For each of your symptoms, circle the appropriate figure in the point score column:
Occasional or mild.....1 point
Frequent and/or moderately severe .....2 points
Severe and/or disabling.....3 points
Add the points and record your total score for Section C in the Total Score, Section C box.

Question	Point Score		
1. Drowsiness	**1**	**2**	**3**
2. Irritability or jitteriness	**1**	**2**	**3**
3. Uncoordination	**1**	**2**	**3**
4. Inability to concentrate	**1**	**2**	**3**
5. Frequent mood swings	**1**	**2**	**3**
6. Headache	**1**	**2**	**3**
7. Dizziness/loss of balance	**1**	**2**	**3**
8. Pressure above ears feeling of head swelling	**1**	**2**	**3**
9. Itching	**1**	**2**	**3**

10. Rashes	**1**	**2**	**3**
11. Heartburn	**1**	**2**	**3**
12. Indigestion	**1**	**2**	**3**
13. Belching and/or intestinal gas	**1**	**2**	**3**
14. Mucus in stools	**1**	**2**	**3**
15. Hemorrhoids	**1**	**2**	**3**
16. Dry mouth	**1**	**2**	**3**
17. Rash or blisters in mouth	**1**	**2**	**3**
18. Bad breath	**1**	**2**	**3**
19. Endometriosis	**1**	**2**	**3**
20. Nasal congestion or discharge	**1**	**2**	**3**
21. Postnasal drip	**1**	**2**	**3**
22. Nasal itching	**1**	**2**	**3**
23. Sore or dry throat	**1**	**2**	**3**
24. Cough	**1**	**2**	**3**
25. Pain or tightness in chest	**1**	**2**	**3**
26. Wheezing or shortness of breath	**1**	**2**	**3**
27. Urinary urgency or frequency	**1**	**2**	**3**
28. Burning on urination	**1**	**2**	**3**
29. Failing vision	**1**	**2**	**3**
30. Burning or tearing of eyes	**1**	**2**	**3**
31. Recurrent infections or fluid in ears	**1**	**2**	**3**
32. Ear pain or deafness	**1**	**2**	**3**
TOTAL SCORE, SECTION C			

TOTAL SCORE, SECTION A	
TOTAL SCORE, SECTION B	
TOTAL SCORE, SECTION C	
GRAND TOTAL SCORE	

Your Grand Total Score will help you and your doctor decide if your health problems are yeast related. Scores in females will run higher as seven items in the questionnaire apply exclusively to females while only two apply only to males.

If your score is:	**Symptoms relating to yeast are:**
180 (Female)	**Almost Certain Yeast Related**
140 (Male)	**Almost Certain Yeast Related**
120 (Female)	**Probably Yeast Related**
90 (Male)	**Probably Yeast Related**
Less Than:	
60 (Female)	**Probably Not Yeast Related**
40 (Male)	**Probably Not Yeast Related**

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