

# Yeast Questionnaire and Score Sheet

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. 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 the section. The move on to Section B and C and score as indicated. 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. Record your total score in the space at the end of the section.

- |   | <b>Point Score</b> |
|---|--------------------|
| 1. Have you ever taken tetracyclines (Symycin®, Vibramycin®, etc.) or other antibiotics for acne for one month or longer?   | <b>35</b>          |
| 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 or more times in a one year period? | <b>35</b>          |
| 3. Have you taken a broad spectrum antibiotic* — even in a single course?   | <b>6</b>           |
| 4. Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis or other problems affecting your reproductive organs?   | <b>25</b>          |
| 5. Have you been pregnant ...   |                    |
| Two or more times?  | <b>5</b>           |
| One time?   | <b>3</b>           |
| 6. Have you taken birth control pills ...   |                    |
| More than two years?  | <b>15</b>          |
| Six months to two years?  | <b>8</b>           |

Including Kelflex®, ampicillin, amoxicillin, Ceclor®, Bactrim®, and Septra®. Such antibiotics fill off "good bacteria" while they are killing off those that cause infection.

- |  |           |
|--|-----------|
| 7. Have you taken Prednisone®, Decadron®, or other cortisone-type drugs ...                                      |           |
| More than two years?   | <b>15</b> |
| Six months to two years?   | <b>6</b>  |
| 8. Does exposure to perfumes, insecticides, fabric shop odors, and other chemicals provoke ...                   |           |
| Moderate to severe symptoms?   | <b>20</b> |
| Mild symptoms?   | <b>5</b>  |
| 9. Are your symptoms worse on damp, muggy days or in moldy places?   | <b>20</b> |
| 10. Have you had athlete's foot, ring worm, jock itch or other chronic fungus infections of the skin or nails... |           |
| More than two years?   | <b>20</b> |
| Six months to two years?   | <b>10</b> |
| 11. Do you crave sugar?  | <b>10</b> |
| 12. Do you crave bread?  | <b>10</b> |
| 13. Do you crave alcoholic beverages?  | <b>10</b> |
| 14. Does tobacco smoke really bother you?  | <b>10</b> |

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

## Section B: Major Symptoms

For each of your symptoms, enter the appropriate figure in the point score column:

- |                                       |                 |
|---------------------------------------|-----------------|
| Occasional or mild ...                | <b>3 points</b> |
| Frequent and/or moderately severe ... | <b>6 points</b> |
| Severe and/or disabling ...           | <b>9 points</b> |

Add points and record your total score at the end of this section.

- |                                 | <b>Point Score</b> |
|---------------------------------|--------------------|
| 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                                  | _____ |
| 17. Impotence                                    | _____ |
| 18. Loss of sexual desire                        | _____ |
| 19. Endometriosis                                | _____ |
| 20. Cramps and/or other menstrual Irregularities | _____ |
| 21. Premenstrual tension                         | _____ |
| 22. Spots in front of the eyes                   | _____ |
| 23. Erratic vision                               | _____ |

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

## Section C: Other Symptoms

For each of your symptoms, enter the appropriate figure in the point score column:

- |                                       |                 |
|---------------------------------------|-----------------|
| Occasional or mild ...                | <b>1 points</b> |
| Frequent and/or moderately severe ... | <b>2 points</b> |
| Severe and/or disabling ...           | <b>3 points</b> |

Add points and record your total score at the end of this section.

- |                                | <b>Point Score</b> |
|--------------------------------|--------------------|
| 1. Drowsiness                  | _____              |
| 2. Irritability or jitteriness | _____              |
| 3. Uncoordination              | _____              |
| 4. Inability to concentrate    | _____              |
| 5. Frequent mood swings        | _____              |

- 6. Headache \_\_\_\_\_
- 7. Dizziness/loss of balance \_\_\_\_\_
- 8. Pressure above ears, feeling of head swelling \_\_\_\_\_
- 9. Itching \_\_\_\_\_
- 10. Rashes \_\_\_\_\_
- 11. Heartburn \_\_\_\_\_
- 12. Indigestion \_\_\_\_\_
- 13. Belching and/or intestinal gas \_\_\_\_\_
- 14. Mucus in stools \_\_\_\_\_
- 15. Hemorrhoids \_\_\_\_\_
- 16. Dry mouth \_\_\_\_\_
- 17. Rash or blisters in mouth \_\_\_\_\_
- 18. Bad breath \_\_\_\_\_
- 19. Endometriosis \_\_\_\_\_
- 20. Nasal congestion or discharge \_\_\_\_\_
- 21. Postnasal drip \_\_\_\_\_
- 22. Nasal itching \_\_\_\_\_
- 23. Sore or dry throat \_\_\_\_\_
- 24. Cough \_\_\_\_\_
- 25. Pain or tightness in chest \_\_\_\_\_
- 26. Wheezing or shortness of breath \_\_\_\_\_
- 27. Urinary urgency or frequency \_\_\_\_\_
- 28. Burning on urination \_\_\_\_\_
- 29. Failing vision \_\_\_\_\_
- 30. Burning or tearing of eyes \_\_\_\_\_
- 31. Recurrent infections or fluid in ears \_\_\_\_\_
- 32. Ear pain or deafness \_\_\_\_\_

**Total Score, Section C:** \_\_\_\_\_

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

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

**GRAND TOTAL SCORE:** \_\_\_\_\_

Your **Grand Total Score** will help you and your doctor decide if your health problems are yeast connected. 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:**

**180 (Female)**

**140 (Male)**

**120 (Female)**

**90 (Male)**

**Less than:**

**60 (Female)**

**40 (Male)**

**Symptoms are:**

**Almost Certainly**

**Yeast Connected**

**Probably Yeast**

**Connected**

**Probably Not**

**Yeast Connected**

# Yeast Questionnaire

## Symptoms Questionnaire and Score Sheet

☆☆☆ Don't Forget ☆☆☆  
Bring the completed form with you to your next appointment

Name \_\_\_\_\_

Age \_\_\_\_\_