Lifestyle For Health – Candida History and Checklist Questionnaire

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Name_____ **Date** _____

Candida Self Analysis

The following History and Major Symptom Checklist will help determine is Candida is a possible health challenge for you. If you have any questions, please call our office: 719-488-5688

History – Section 1

This section involves an understanding of your medical history and how it may have promoted Candida growth. Enter the points beside each question that is true for you. Record your total at the end of the section.

			Points
1	___	Throughout your lifetime, have you taken any antibiotics or tetracyclines (Symycim™, Panmycin™, Bivramycin™, Monicin™, etc.) for acne or other conditions, for more than one month?	25
2	___	Have you ever taken a "broad spectrum" antibiotic for more than two months, or four or more times in a one-year period? These could include any antibiotics taken for respiratory, urinary or other infections.	20
3	___	Have you taken a "broad spectrum" antibiotic – even for a single course? These antibiotics include ampicillin™, amoxicillin™, Keflex™, etc.	6
4	___	Have you ever had problems with persistent prostatitis, vaginitis or other problems with your reproductive organs?	25
5	___	Women – Have you been pregnant:	
		Two or more times?	5
		One time?	3
6	___	Women – Have you taken birth control pills:	
		More than two years?	15
		More than six months?	8
7	___	If you were not breast-fed as an infant.	9
8	___	Have you taken any cortisone-type drugs (Predinisone™, Decadron™, etc.)	15
9	___	Are you sensitive to and bothered by exposure to perfumes, insecticides or other chemical odors:	
		Do you have moderate to severe symptoms?	20
		Do you have mild symptoms?	5
10	___	Does tobacco smoke bother you?	10
11	___	Are your symptoms worse on damp, muggy days or in moldy places?	20

12 ___ If you have had chronic fungus infections of the skin or nails (including athlete's foot, ring worm, jock itch), have the infections been?

Severe or persistent?	20
Mild to moderate?	10

13 ___ Do you crave sugar (chocolate, ice cream, candy, cookies, etc.)? 10

14 ___ Do you crave carbohydrates (bread, bread and more bread)? 10

15 ___ Do you crave alcoholic beverages? 10

16 ___ Have you drunk or do you drink chlorinated water (city or tap)? 20

_____ Total Score Section 1

Major Symptoms – Section 2

For each of your symptoms, enter the appropriate score next to the symptom.
Record your total at the end of the section.

No symptoms	0
Occasional or mild	3
Frequent and/or moderately severe	6
Severe and/or disabling	9

1 ___ Constipation

2 ___ Diarrhea

3 ___ Bloating

4 ___ Fatigue or lethargy

5 ___ Feeling drained

6 ___ Poor memory

7 ___ Difficulty focusing / brain fog

8 ___ Feeling moody or despair

9 ___ Numbness, burning or tingling

10 ___ Muscle aches

11 ___ Nasal congestion or discharge

12 ___ Pain and/or swelling in the joints

13 ___ Abdominal pain

14 ___ Spots in front of the eyes

15 ___ Erratic vision

16 ___ Cold hands and/or feet

17 ___ Loss of sexual desire

18 ___ Low blood sugar

19 ___ Anger or frustration

20 ___ Dry, patchy skin

Women only:

17 ___ Endometriosis

18 ___ Menstrual irregularities and/or severe cramps

19 ___ PMS

20 ___ Vaginal discharge

21 ___ Persistent vaginal burning or itching

Men only:

22 ___ Prostatitis

23 ___ Impotence

_____ Total Score Section 2

Minor Symptoms – Section 3

For each of your symptoms, enter the appropriate score next to the symptom.
Record your total at the end of the section.

No symptoms	0
Occasional or mild	1
Frequent and/or moderately severe	2
Severe and/or disabling	3

1 ___ Heartburn

2 ___ Indigestion

3 ___ Belching and intestinal gas

4 ___ Drowsiness

5 ___ Itching

6 ___ Rashes

7 ___ Irritability or jitters

8 ___ Uncoordinated

9 ___ Inability to concentrate

10 ___ Frequent mood swings

11 ___ Postnasal drip

12 ___ Nasal itching

13 ___ Failing vision

14 ___ Burning or tearing of the eyes

15 ___ Recurrent infections of fluid in the ears

16 ___ Ear pain or deafness

17 ___ Headaches

18 ___ Dizziness / loss of balance

19 ___ Pressure above the ears (your head feels like it is swelling and tingling)

20 ___ Mucus in the stool

21 ___ Hemorrhoids

22 ___ Dry mouth

23 ___ Rash or blisters in the mouth

24 ___ Bad breath

25 ___ Sore or dry throat

26 ___ Cough

27 ___ Pain or tightness in the chest

28 ___ Wheezing or shortness of breath

29 ___ Urinary urgency or frequency

30 ___ Burning during urination

_____ Total Score Section 3

The Results

Follow the directions at the top of the questionnaire and subtotal for each Section.

Total Score from Section 1 _____

Total Score from Section 2 _____

Total Score from Section 3 _____

Total Score _____

If your total score is at least:	*Your symptoms are:*
180 Women	Almost certainly Candida (yeast) connected
140 Men	Almost certainly Candida (yeast) connected
120 Women	Probably Candida (yeast) connected
90 Men	Probably Candida (yeast) connected
60 Women	Possibly Candida (yeast) connected
40 Men	Possibly Candida (yeast) connected
< 60 Women	Probably NOT Candida (yeast) connected
<40 Men	Probably NOT Candida (yeast) connected

If your score is 60+ (women) or 40+ (men), then you will probably want to consider following the recommended Candida Cleanse steps to reduce symptoms. If you have any questions, you can schedule a phone consultation with Cheryl Townsley.