Patient Name:_________________________________ **Date:**___________________

Candida Questionnaire and Score Sheet

Filling out and scoring this questionnaire should help us evaluate the possible role *Candida albicans* contributes to your health problems.

Section A: History

	If YES, Circle Score
1. Have you taken tetracyclines or other antibiotics for acne for 1 month (or longer)?	**35**
2. Have you at any time in your life taken antibiotics or other antibacterial medication for respiratory, urinary or other infections for two months or longer, or in shorter courses four or more times in a one-year period?	**35**
3. Have you taken an antibiotic drug—even in a single dose?	**6**
4. Have you, at any time in your life, been bothered by persistent prostate infection, vaginitis or other problems affecting your reproductive organs?	**25**
5. Are you bothered by memory or concentration problems—do you sometimes feels spaced out?	**20**
6. Do you feel "sick all over" yet, in spite of visits to many different physicians, the causes haven't been found?	**20**
7. Have you been pregnant…	
Two or more times?	**5**
One time	**3**
8. Have you taken birth control pills…	
For more than two years?	**15**
For six months to two years?	**8**
9. Have you taken steroids orally, by injection or inhalation?	
For more than two weeks?	**15**
For two weeks or less?	**6**
10. Does exposure to perfumes, insecticides, fabric shop odors and other chemicals provoke…	
Moderate to severe symptoms?	**20**
Mild symptoms?	**5**
11. Does tobacco smoke really bother you?	**10**
12. Are your symptoms worse on damp, muggy days or in moldy places?	**20**
13. Have you had athlete's foot, ring worm, "jock itch" or other chronic fungous infections of the skin or nails? Have such infections been…	
Severe or persistent?	**20**
Mild to moderate?	**10**
14. Do you crave sugar?	**10**
Total Score, Section A	

Section B: Major Symptoms

For each of your symptoms, CIRCLE the appropriate number in the Point Score Column:

If a symptom is **occasional or mild**……………………………………………….3 points
If a symptom is **frequent and/or moderately severe**……………………………6 points
If a symptom is **severe and/or disabling**………………………………………..9 points

		Point Score
1.	Fatigue or lethargy (lack of energy)	**3 6 9**
2.	Feeling of being “drained”	**3 6 9**
3.	Depression or manic depression	**3 6 9**
4.	Numbness, burning or tingling	**3 6 9**
5.	Headache	**3 6 9**
6.	Muscle aches	**3 6 9**
7.	Pain and/or swelling or paralysis	**3 6 9**
8.	Muscle weakness or paralysis	**3 6 9**
9.	Abdominal pain	**3 6 9**
10.	Constipation and/or diarrhea	**3 6 9**
11.	Bloating, belching or intestinal gas	**3 6 9**
12.	Troublesome vaginal burning, itching or discharge	**3 6 9**
13.	Prostatitis (Infection of the prostate)	**3 6 9**
14.	Impotence	**3 6 9**
15.	Loss of sexual desire or feeling	**3 6 9**
16.	Endometriosis or infertility	**3 6 9**
17.	Cramps and/or other menstrual irregularities	**3 6 9**
18.	Premenstrual tension	**3 6 9**
19.	Attacks of anxiety or crying	**3 6 9**
20.	Cold hands or feet, low body temperature	**3 6 9**
21.	Hypothyroidism	**3 6 9**
22.	Shaking or irritable when hungry	**3 6 9**
23.	Cystitis or interstitial cystitis (Chronic Inflammation of the bladder)	**3 6 9**
Total Score, Section B		

Section C: Other Symptoms

For each of your symptoms, CIRCLE the appropriate number in the Point Score Column:

If a symptom is **occasional or mild**…………………………………………………...1 point
If a symptom is **frequent and/or moderately severe**………………………………...2 points
If a symptom is **severe and/or disabling**……………………………………………...3 points

	Point Score
1. Drowsiness, including inappropriate drowsiness	**1 2 3**
2. Irritability	**1 2 3**
3. Incoordination	**1 2 3**
4. Frequent mood swings	**1 2 3**
5. Insomnia	**1 2 3**
6. Dizziness/loss of balance	**1 2 3**
7. Pressure above ears...feeling of head swelling	**1 2 3**
8. Sinus problems...tenderness of cheekbones or forehead	**1 2 3**
9. Tendency to bruise easily	**1 2 3**
10. Eczema, itching eyes	**1 2 3**
11. Psoriasis	**1 2 3**
12. Chronic hives (urticaria)	**1 2 3**
13. Indigestion or heartburn	**1 2 3**
14. Sensitivity to milk, wheat, corn or other common foods	**1 2 3**
15. Mucus in stools	**1 2 3**
16. Rectal itching	**1 2 3**
17. Dry mouth or throat	**1 2 3**
18. Mouth rashes, including “white” tongue	**1 2 3**
19. Bad breath	**1 2 3**
20. Foot, hair or body odor not relieved by washing	**1 2 3**
21. Nasal congestion or postnasal drip	**1 2 3**
22. Nasal itching	**1 2 3**
23. Sore throat	**1 2 3**
24. Laryngitis, loss of voice	**1 2 3**
25. Cough or recurrent bronchitis	**1 2 3**
26. Pain or tightness in chest	**1 2 3**
27. Wheezing or shortness of breath	**1 2 3**
28. Urinary frequency or urgency	**1 2 3**
29. Burning on urination	**1 2 3**
30. Spots in front of eyes or erratic vision	**1 2 3**
31. Recurrent infections or fluid in ears	**1 2 3**
32. Burning or tearing eyes	**1 2 3**
33. Ear pain or deafness	**1 2 3**
Total Score, Section C	

Total Section A:__________

+ Total Section B:__________

+ Total Section C:__________

Grand Total:___________