

# CANDIDA QUESTIONNAIRE

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please answer Yes or No to the following questions by filling in the appropriate circle.

**Have you:**

	YES	NO
Taken antibiotics for over one month?	<input type="radio"/>	<input type="radio"/>
Taken antibiotics on at least six occasions in your life?	<input type="radio"/>	<input type="radio"/>
Taken prednisone, cortisone, ACTH or other steroids?	<input type="radio"/>	<input type="radio"/>
Taken immunosuppressant drugs (drugs to suppress the immune system)?	<input type="radio"/>	<input type="radio"/>
Drank chlorinated tap water on a regular basis (this includes any tap water that comes from any municipal water system, but not from your own well)?	<input type="radio"/>	<input type="radio"/>
Been treated with chemotherapy?	<input type="radio"/>	<input type="radio"/>
Suffered from HIV, A.I.D.S. or other immune suppressing illnesses?	<input type="radio"/>	<input type="radio"/>
Been diagnosed with any form of diabetes?	<input type="radio"/>	<input type="radio"/>
Been diagnosed with any muscular disorder (fibromyalgia, muscular sclerosis, muscular dystrophy, etc?)	<input type="radio"/>	<input type="radio"/>
Been pregnant more than once?	<input type="radio"/>	<input type="radio"/>

**Have you had:**

Whitish vaginal discharge or irritation?	<input type="radio"/>	<input type="radio"/>
More than three vaginal, yeast infections?	<input type="radio"/>	<input type="radio"/>
Bladder infections?	<input type="radio"/>	<input type="radio"/>
Prostate irritation?	<input type="radio"/>	<input type="radio"/>
Erratic vision, floaters in the eyes, spots before the eyes?	<input type="radio"/>	<input type="radio"/>
Impotence or decreased sexual desires?	<input type="radio"/>	<input type="radio"/>
Endometriosis?	<input type="radio"/>	<input type="radio"/>
Oral thrush (white, yellow or cream colored spots or coating in mouth and throat, sometimes with bad breath)?	<input type="radio"/>	<input type="radio"/>
Athlete's foot, persistent crotch or renal itch, or fungal infection of the nails or skin?	<input type="radio"/>	<input type="radio"/>
High sensitivity to chemical fumes, perfume, tobacco smoke?	<input type="radio"/>	<input type="radio"/>
Cravings for sugar (chocolate, ice cream, cookies, cakes, pies, candies, etc..) or other simple carbohydrates (bread, pasta, etc.)?	<input type="radio"/>	<input type="radio"/>
Light-headed feelings, or feelings somewhat like intoxication, after eating sugar or other simple carbohydrates?	<input type="radio"/>	<input type="radio"/>

**Other Symptoms, Including:**

Abdominal distention or bloating?	<input type="radio"/>	<input type="radio"/>
Clothes fitting tighter at the end of the day?	<input type="radio"/>	<input type="radio"/>
Diarrhea and/or constipation?	<input type="radio"/>	<input type="radio"/>
PMS, menstrual cramps or pain?	<input type="radio"/>	<input type="radio"/>
Fatigue, lethargy, poor memory?	<input type="radio"/>	<input type="radio"/>
Mood swings, feeling "spaced out"?	<input type="radio"/>	<input type="radio"/>
Cravings for cheeses, vinegars or alcohol?	<input type="radio"/>	<input type="radio"/>
Unaccountable muscle aches, tingling, numbness?	<input type="radio"/>	<input type="radio"/>
Burning, swollen, aching joints?	<input type="radio"/>	<input type="radio"/>

If you answered yes to two or more of these questions, you may have a health challenge that involves the fungal yeast known as *Candida albicans*. This yeast is estimated to affect over half the adult population in the United States, as well as high numbers of infants and children.