The Healing Arts Partnership

Yeast Questionaire

The total score for this section gives us the probability of yeast overgrowth being a significant factor in your case.

Score	SECTION A: YOUR MEDICAL HISTORY	Point
_____	Have you been treated for acne with tetracycline, erythromycin, or any other antibiotic for one month or longer?	50
_____	Have you taken antibiotics for any type of infection for more than two consecutive months, or in shorter courses four or more times in a twelve-month period?	50
_____	Have you ever taken an antibiotic – even for a single course?	6
_____	Have you ever had prostatitis, vaginitis, or another infection or problem with your reproductive organs for more than one month?	25
	Have you ever been pregnant:	
_____	Two or more times?	5
_____	Once?	3
	Have you taken birth control pills for:	
_____	More than two years?	15
_____	Six months to two years?	
	Have you taken corticosteroids such as Prednisone, Cortef, or Medrol by mouth or inhaler for:	
_____	More than two weeks?	15
_____	Two weeks or less?	6
	When you are exposed to perfumes, insecticides, or other odors or chemicals, do you develop wheezing, burning eyes, taste metal in your mouth or any other distress?	
_____	Yes, and the symptoms keep me from continuing my activities.	20
_____	Yes, but the symptoms are mild and do not change my activities.	5
_____	Are your symptoms worse on damp or humid days or in moldy places?	20
	Have you ever had a fungal infection, such as jock itch, athlete's foot, or a nail or skin infection, that was difficult to treat and:	
_____	Lasted for more than two months?	20
_____	Lasted less than two months?	10
	Do you crave?	
_____	Sugar?	10
_____	Breads?	10
_____	Alcoholic beverages?	10
_____	Does tobacco smoke cause you discomfort such as wheezing, burning eyes, or another problem?	10

Total _____

SECTION B: MAJOR SYMPTOMS

For each symptom that is present, enter the appropriate number in the point score column:

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

Score		Point
1.	Fatigue or lethargy.	_____
2.	Feeling of being “drained.”	_____
3.	Poor memory.	_____
4.	Feeling “spacey” or “unreal.”	_____
5.	Inability to make decisions.	_____
6.	Numbness, burning, or tingling.	_____
7.	Insomnia.	_____
8.	Muscle aches.	_____
9.	Muscle weakness or paralysis.	_____
10.	Pain and/or swelling in joints.	_____
11.	Abdominal pain.	_____
12.	Constipation.	_____
13.	Diarrhea.	_____
14.	Bloating, belching or intestinal gas.	_____
15.	Troublesome vaginal burning, itching, or discharge.	_____
16.	Prostatitis	_____
17.	Impotence	_____
18.	Loss of sexual desire or feeling	_____
19.	Endometriosis or infertility	_____
20.	Cramps and/or other menstrual irregularities	_____
21.	Premenstrual tension	_____
22.	Attacks of anxiety or crying	_____
23.	Cold hands or feet and/or Chilliness	_____
24.	Shaking or irritable when hungry	_____

Total _____

Section C: Other Symptoms

For each symptom that is present, enter the appropriate figure in the point score column.

If a symptom is occasional or mild	Score 1 point
If a symptom is frequent and/or moderately severe	Score 2 points
If a symptom is severe and/or persistent	Score 3 points

Symptom	Point Score
1. Drowsiness	_____
2. Irritability or jitteriness	_____
3. Lack of coordination	_____
4. Inability to concentrate	_____
5. Frequent moos swings	_____
6. Headache	_____
7. Dizziness, loss of balance	_____
8. Pressure above ears, feeling of head swelling	_____
9. Tendency to bruise easily	_____
10. Chronic rashes or itching	_____
11. Psoriasis or recurrent hives	_____
12. Indigestion or heartburn	_____
13. Food sensitivity or intolerance	_____
14. Mucous in stools	_____
15. Rectal itching	_____
16. Dry mouth or throat	_____
17. Rash or blisters in mouth	_____
18. Bad breath	_____
19. Foot, hair, or body odor not relieved by washing	_____
20. Nasal congestion or postnasal drip	_____
21. Nasal itching	_____
22. Sore Throat	_____
23. Laryngitis, loss of voice	_____
24. Cough or recurrent bronchitis	_____
25. Pain or tightness in chest	_____
26. Wheezing or shortness of breath	_____
27. Urinary frequency, urgency, or incontinence	_____
28. Burning on urination	_____
29. Spots in front of eyes or erratic vision	_____
30. Burning or tearing of eyes	_____
31. Recurrent infections or fluids in ears	_____
32. Ear pain or deafness	_____
Total	_____

Yeast Score _____

(Add pages 1,2 &3)