SECTION A: HISTORY

	Point Score
1. Have you taken tetracycline or other antibiotics for one month or longer?	35
2. Have you at any time in your life taken broad-spectrum 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 a broad-spectrum antibiotic drug – even in a single dose?	6
4. Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis or other problems affecting your reproductive organs?	25
5. Are you bothered by memory or concentration problems – do you sometimes feel 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 tow 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, ringworm, “jock itch” or other chronic fungus 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, enter the appropriate figure 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

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

	Point Score
1. Fatigue or lethargy	________
2. Feeling of being “drained”	________
3. Depression or manic depression	________
4. Numbness, burning or tingling	________
5. Headaches	________
6. Muscle aches	________
7. Muscle weakness or paralysis	________
8. Pain and/or swelling in joints	________
9. Abdominal pain	________
10. Constipation and/or diarrhea	________
11. Bloating, belching or intestinal gas	________
12. Troublesome vaginal burning, itching or discharge	________
13. Prostatitis	________
14. Impotence	________
15. Loss of sexual desire or feeling	________
16. Endometriosis or infertility	________
17. Cramps and/or diarrhea	________
18. Premenstrual tension	________
19. Attacks of anxiety or crying	________
20. Cold hands or feet, low body temperature	________
21. Hypothyroidism	________
22. Shaking or irritability when hungry	________
23. Cystitis or interstitial cystitis	________

Total Score, Section B __________

SECTION C: OTHER SYMPTOMS

For each of your symptoms, enter the appropriate figure 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

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

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

Total Score, Section A ___________
Total Score, Section B ___________
Total Score, Section C ___________
GRAND TOTAL SCORE ___________

The Grand Total Score will help you ad your physician decide if your health problems are yeast connected. Scores in women will run higher, as seven items in the questionnaire apply exclusively to women, while only two apply exclusively to men.

- Yeast-connected health problems are almost certainly present in women with scores over 180, and in men with scores over 140.
- Yeast-connected health problems are probably present in women with scores over 120, and in men with scores over 90.
- Yeast-connected health problems are possibly present in women with scores over 60, and in men with scores over 40.
- With scores of less than 60 in women and 40 in men, yeasts are less apt to cause health problems.