CANDIDA HISTORY & CHECKLIST FORMS

Candida Self Analysis

The following History and Major Symptom Checklist has been prepared by Lindsey Duncan, CN. And CEO of Nature's Secret. These support materials are provided based on his permission.

History – Section 1

This section involves an understanding of your medical history and how it may have promoted Candida growth. Circle those comment to which you can answer yes. Record your total at the end of the section.

	Points
1. Throughout your lifetime, have you taken any antibiotics or tetracyclines (Symycin™, 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 (Prednisone™, 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

	Points
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 figure in the point score column.

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

	Points
1. Constipation	____
2. Diarrhea	____
3. Bloating	____

	Points
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	____
Women	
17. Endometriosis	____
18. Menstrual irregularities and/or severe cramps	____
19. PMS	____
20. Vaginal discharge	____
21. Persistent vaginal burning or itching	____
Men	
22. Prostatitis	____
23. Impotence	____
Women and Men	
24. Loss of sexual desire	____
25. Low blood sugar	____
26. Anger or frustration	____
27. Dry, patchy skin	____
Total Score Section 2	**____**

Minor Symptoms – Section 3

For each of your symptoms, enter the appropriate figure in the point score column.

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

	Points
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	____

	Points
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

Total Score from Section 1	_____
Total Score from Section 2	_____
Total Score from Section 3	_____
Total Score	**_____**

If your score is at least:	*Your symptoms are:*
180 Women	Almost certainly yeast connected
140 Men	Almost certainly yeast connected
120 Women	Probably yeast connected
90 Men	Probably yeast connected
60 Women	Possibly yeast connected
40 Men	Possibly yeast connected
60 Women	Probably not yeast connected
40 Men	Probably not yeast connected

If your score is 60+ (women) or 40+ (men), then you will probably want to consider following the suggestions found in this book Body By Design.