

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

SECTION A: YOUR MEDICAL HISTORY

Score	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?	15
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)