



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.

	<i>Points</i>
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



	<i>Points</i>
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

	<i>Points</i>
1. Constipation	_____
2. Diarrhea	_____
3. Bloating	_____
4. Fatigue or lethargy	_____
5. Feeling drained	_____



Points

- | | |
|---------------------------------------------------|-------|
| 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 | _____ |
| <i>Women</i> | |
| 17. Endometriosis | _____ |
| 18. Menstrual irregularities and/or severe cramps | _____ |
| 19. PMS | _____ |
| 20. Vaginal discharge | _____ |
| 21. Persistent vaginal burning or itching | _____ |
| <i>Men</i> | |
| 22. Prostatitis | _____ |
| 23. Impotence | _____ |
| <i>Women and Men</i> | |
| 24. Loss of sexual desire | _____ |



Points

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



If your score is less than:

Your symptoms are:

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.