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## **CANDIDA PROFILE QUESTIONNAIRE**

*This profile looks for significant factors that encourage the overgrowth of the common yeast known as Candida Albicans. It also includes symptoms that are indicators of Candida Overgrowth which can greatly undermine your health.*

### **PHASE ONE:**

***Check yes or no for each question. Please note that instructions are different for Phase Two.***

Have you taken antibiotics for acne for a period of one month or longer?  YES  NO

Have you at any time in the past taken antibiotics for any type of infection for 2 months straight or longer, or for shorter periods 4 or more times in one year, or by IV related to surgery?  YES  NO

Have you ever had persistent and/or recurring prostatitis or vaginal yeast infections?  YES  NO

If female, have you been pregnant?  YES  NO If yes, how many times? \_\_\_\_\_

If female, have you taken Birth Control pills?  YES  NO If yes, how long? \_\_\_\_\_

Have you taken any form of prednisone or other cortisone – type drugs including nasal inhalers and bronchial sprays?  YES  NO

Have you had any chronic fungus infections of the skin or nails such as athlete's foot, jock itch, nail fungus, ringworm etc?  YES  NO

Are your symptom's worse in humid climates, on muggy days, or in mildewed places?  YES  NO

## PHASE TWO

Check the following **ONLY** if the issue is **frequent** and **moderate** to **severe** in effect. Do **NOT** check if it is only *mild* or *infrequent*.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Crave sweet foods or beverages   | <input type="checkbox"/> Skin Rash or Hives         | <input type="checkbox"/> Water Retention  |
| <input type="checkbox"/> Crave breads in any form   | <input type="checkbox"/> Mood Swings                | <input type="checkbox"/> Iron Deficiency  |
| <input type="checkbox"/> Crave alcoholic beverages  | <input type="checkbox"/> Adrenal or Thyroid Issues  | <input type="checkbox"/> Acne   |
| <input type="checkbox"/> Chemicals, perfumes, soaps, cleaners, pest control products, etc. cause moderate to severe physical symptoms | <input type="checkbox"/> Insomnia                   | <input type="checkbox"/> Inability to Make Decisions                              |
| <input type="checkbox"/> Tobacco smoke greatly bothers you  | <input type="checkbox"/> Cold/Shaky                 | <input type="checkbox"/> Muscle Aches   |
| <input type="checkbox"/> Gas/Bloating   | <input type="checkbox"/> Over or Under Weight       | <input type="checkbox"/> Muscle Weakness or Paralysis                             |
| <input type="checkbox"/> Diarrhea   | <input type="checkbox"/> Poor Memory                | <input type="checkbox"/> Numbness, Burning or Tingling                            |
| <input type="checkbox"/> Depression   | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Loss of Sexual Desire or Function                        |
| <input type="checkbox"/> Headaches  | <input type="checkbox"/> Bladder Infections         | <input type="checkbox"/> Anxiety Attacks or Frequent Crying                       |
| <input type="checkbox"/> Fatigue or Lethargy  | <input type="checkbox"/> Indigestion                | <input type="checkbox"/> Cold Hands or Feet                                       |
| <input type="checkbox"/> Low Blood Sugar  | <input type="checkbox"/> Constipation               | <input type="checkbox"/> Shaking or Irritable When Hungry                         |
| <input type="checkbox"/> Respiratory Problems   | <input type="checkbox"/> Intestinal Pain            | <input type="checkbox"/> Unusual or Persistent Itching Anywhere In or On the Body |
| <input type="checkbox"/> Dry Skin and Itching   | <input type="checkbox"/> Hyperactivity              | <input type="checkbox"/> Urinary Frequency, Urgency, or Incontinence              |
| <input type="checkbox"/> Joint Pain   | <input type="checkbox"/> Menstrual Problems         | <input type="checkbox"/> Recurrent Infections                                     |
| <input type="checkbox"/> Food or Environmental Allergies  | <input type="checkbox"/> Endometriosis              | <input type="checkbox"/> Recurrent Fluid in Ears                                  |
| <input type="checkbox"/> Dry Mouth  | <input type="checkbox"/> Infertility                |   |
| <input type="checkbox"/> Irritability   | <input type="checkbox"/> Feeling of "Being Drained" |   |
| <input type="checkbox"/> Hair Loss  | <input type="checkbox"/> Thrush or Receding Gums    |   |
| <input type="checkbox"/> Weakened Sex Drive   | <input type="checkbox"/> Dizziness                  |   |
|   | <input type="checkbox"/> Bad Breath                 |   |
|   | <input type="checkbox"/> Bad Taste                  |   |
|   | <input type="checkbox"/> Colitis                    |   |
|   | <input type="checkbox"/> Heartburn                  |   |