QUESTIONNAIRE
Candida Self-Assessment

Perth Allergy Clinic
NATURAL HEALTH AND SCIENCE COMBINED

Full Name:		**Date:**	
Contact Phone Number:			
Email Address:			

Gender:	Male	Female	Not specified

		Yes	No
1.	Have you taken tetracycline or other antibiotics for acne for 1 month or longer?		
2.	Have you (any time in your life) taken antibiotics for respiratory, urinary or other infections?		
3.	Have you at any time in your life been bothered by persistent vaginitis, endometriosis or any other reproductive problems?		
4.	Have you taken birth control pills?		
5.	Have you at any time experienced persistent prostatitis (enlarged or inflamed prostate or elevated PSA blood test) or other male yeast problems?		
6.	Have you taken prednisone or any other cortisone-type drug such as inhaled steroids or hydrocortisone (for skin problems)?		
7.	Does exposure to the smell of perfumes, insecticides and other chemicals affect you?		
8.	Have you had athlete's foot, ringworm, other fungal infections of the skin or nails?		
9.	Do you crave sugar, chocolate anything sweet?		
10.	Do you crave salty potato crisps, salted nuts, anything salty?		
11.	Do you crave alcoholic beverages?		
12.	Does tobacco smoke really bother you?		
13.	Are you often fatigued?		
14.	Do you have brain fog or poor memory?		

		Mild	Moderate	Severe	None
15.	Do you suffer with muscle weakness and or painful joints?				

		Yes	No
16.	Do you experience abdominal bloating or gas?		