

flourish NATUROPATHY

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CANDIDA QUESTIONNAIRE

Please tick if any of the following apply to you:

Tick

<input type="checkbox"/>	Abdominal pain
<input type="checkbox"/>	Antibiotic use (over the past three months)
<input type="checkbox"/>	Bad breath or bad taste in the mouth
<input type="checkbox"/>	Bloating
<input type="checkbox"/>	Body odour that is difficult to control
<input type="checkbox"/>	Coated tongue
<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Craving for bread and high-carbohydrate foods
<input type="checkbox"/>	Craving for sugar and sweet foods
<input type="checkbox"/>	Craving for alcohol
<input type="checkbox"/>	Craving for cheese
<input type="checkbox"/>	Diarrhoea
<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	Fungal infections of the skin (e.g. ringworm) or other (e.g. tinea/athlete's foot)?
<input type="checkbox"/>	General feeling of being unwell
<input type="checkbox"/>	Oral contraceptive pill use
<input type="checkbox"/>	Prednisone use (steroid medication – during the past 3 months)
<input type="checkbox"/>	Vaginal discharge
<input type="checkbox"/>	Vaginal itching
<input type="checkbox"/>	Vaginal or urinary tract infections