# HEALTHY GUT QUESTIONNAIRE

Name: _____ Birthdate: _____ Date: _____

**History:** Please indicate if any of the following applies to you.

| | | | |
|---|---|---|---|
| Approximate number of times **antibiotics were used during childhood**? | ☐ 0-1 times | ☐ 2-3 times | ☐ 4+ times |
| Within the **last 5 years**, have you used any antibiotics? | ☐ YES | ☐ NO | ☐ Unknown |
| Are you currently taking any **opiate pain medication**? | ☐ YES | ☐ In the past | ☐ NO |
| Are you currently taking any **proton pump inhibitors**?<br>- If YES, for how long? _____ | ☐ YES | ☐ In the past | ☐ NO |
| Are you currently using long-term **corticosteroids**? | ☐ YES | ☐ In the past | ☐ NO |
| Are you currently using any **medications for diarrhea?** | ☐ YES | ☐ In the past | ☐ NO |
| Have you ever had **thrush**, **vaginal yeast infections** or **fungal skin rashes**? | ☐ YES | ☐ In the past | ☐ NO |
| Have you ever had **food poisoning**?<br>- If YES, how long ago? _____ | ☐ YES | ☐ In the past | ☐ NO |
| Have you been told that you have a problem with **gut motility** (ex: **gastroparesis, delayed transit time**, etc.)? | ☐ YES | ☐ NO | ☐ Unknown |

| **Do you have a history of any of the following?** | | | | | |
|---|---|---|---|---|---|
| Amyloidosis | ☐ YES | ☐ NO | Ileocecal valve removal | ☐ YES | ☐ NO |
| Anatomical or structural abnormalities | ☐ YES | ☐ NO | Immunodeficiency | ☐ YES | ☐ NO |
| Anemia | ☐ YES | ☐ NO | Intra-abdominal adhesions | ☐ YES | ☐ NO |
| Celiac disease | ☐ YES | ☐ NO | Liver cirrhosis | ☐ YES | ☐ NO |
| Chronic pancreatitis | ☐ YES | ☐ NO | Low stomach acid | ☐ YES | ☐ NO |
| Crohn's disease | ☐ YES | ☐ NO | Osteoporosis | ☐ YES | ☐ NO |
| Cystic fibrosis | ☐ YES | ☐ NO | Parkinson's | ☐ YES | ☐ NO |
| Diabetes Mellites | ☐ YES | ☐ NO | Psoriasis or Eczema | ☐ YES | ☐ NO |
| Ehlers-Danlos, Marfan's or another joint hypermobility syndrome | ☐ YES | ☐ NO | Rosacea | ☐ YES | ☐ NO |
| | | | Scleroderma | ☐ YES | ☐ NO |
| Gastric bypass surgery | ☐ YES | ☐ NO | Sjogren's | ☐ YES | ☐ NO |
| Fibromyalgia | ☐ YES | ☐ NO | Ulcerative Colitis | ☐ YES | ☐ NO |

**What is the consistency of your stool?**

| | | | | | | |
|---|---|---|---|---|---|---|
| ☐ Watery, no solid pieces | ☐ Fluffy pieces with ragged edge, mushy | ☐ Soft blobs with clear cut edges | ☐ Smooth and soft snake | ☐ Like a sausage with cracks in surface | ☐ Sausage shaped but lumpy | ☐ Separate hard lumps, like peas, hard to pass |

**Bowel Movements:** Please indicate if any of the following applies to you.

| | | | | | |
|---|---|---|---|---|---|
| How often do you have **bowel movements**? | ☐ Couple times per week | ☐ Every other day | ☐ 1 per day | ☐ 2-3 per day | ☐ 4+ per day |
| Do you have **undigested food in your stool**? | ☐ None | ☐ A couple times per month | ☐ A couple times per week | ☐ At least once a day | ☐ With every bowel movement |
| What is the **color of your stool**? | ☐ Yellow | ☐ Orange | ☐ Light brown | ☐ Dark brown | ☐ Black |
| Have you ever noticed any **blood in your stool**? | ☐ Never | ☐ Only on toilet paper | ☐ Rarely | ☐ A few times | ☐ Every time |
| Have you ever noticed anything that looked like **coffee grounds in your stool?** | ☐ Regularly | | ☐ Rarely | ☐ NEVER | |
| Is your **stool easy to pass**? | ☐ Regularly | | ☐ Rarely | ☐ NEVER | |
| Do you have **urgency** with your bowel movements? | ☐ Regularly | | ☐ Rarely | ☐ NEVER | |
| Do you **notice fat or greasiness** in your stool? | ☐ Regularly | | ☐ Rarely | ☐ NEVER | |
| Does your **stool float**? | ☐ Regularly | | ☐ Rarely | ☐ NEVER | |

**Bloating**: Please indicate if any of these symptoms are present.

| | | | |
|---|---|---|---|
| Do you experience any **bloating or distention**? | ☐ YES | ☐ NO | ☐ Sometimes |
| - If YES, *when is the bloating or distension the worst?* | ☐ Only **Before** meals | ☐ Only **After** meals | ☐ All the time |
| - If YES, *what time of day are symptoms the worst?* | ☐ When you wake up | ☐ End of the day | ☐ All the time |

**Abdominal Discomfort:** Please indicate if any of these symptoms are present.

| | | |
|---|---|---|
| Do you experience any **abdominal pain, cramping or discomfort**?<br>If YES, please answer the following questions: | ☐ YES | ☐ NO |
| - Is the pain ***worse*** *after eating*? | ☐ YES | ☐ NO |
| - Is the pain ***better*** *after eating*? | ☐ YES | ☐ NO |
| - Is the pain ***constant***? | ☐ YES | ☐ NO |
| - Do you ***wake up*** *with abdominal pain*? | ☐ YES | ☐ NO |
| - Do you experience abdominal discomfort *at least* ***once a week****?* | ☐ YES | ☐ NO |
| - Have you experienced abdominal discomfort for the *last* ***3 months or longer?*** | ☐ YES | ☐ NO |
| - Do you notice that your abdominal discomfort is ***associated with a change in your bowel movements?*** | ☐ YES | ☐ NO |
| - Do you notice your abdominal pain ***improves*** with passage of stool? | ☐ YES | ☐ NO |

| Do you experience any of the following symptoms that are severe enough to interfere with your regular activities? | | |
|---|---|---|
| - **Postprandial fullness** (full right after eating) | ☐ YES | ☐ NO |
| - **Early satiety** (get full very quickly while eating) | ☐ YES | ☐ NO |
| - **Epigastric pain** (pain just below ribcage) | ☐ YES | ☐ NO |
| - **Epigastric burning** (burning just below ribcage) | ☐ YES | ☐ NO |
| - Have these symptoms occurred **at least 3 days a week for the last 3 months?** | ☐ YES | ☐ NO |
| - Did these symptoms begin over **6 months ago?** | ☐ YES | ☐ NO |

**Additional Symptoms:** Please indicate if any of these symptoms are present.

| | | |
|---|---|---|
| Do you experience any **flatulence** (passing of gas) **or belching**? | ☐ YES | ☐ NO |
| Do you experience any **nausea**? | ☐ YES | ☐ NO |
| Do you experience any **vomiting**? | ☐ YES | ☐ NO |
| - If YES, does it burn? | ☐ YES | ☐ NO |
| Do you experience any **indigestion** or **heartburn**? | ☐ YES | ☐ NO |
| Have you found that your symptoms are **triggered by any foods**? | ☐ YES | ☐ NO |
| - Are *apples, onions and garlic* noticeable triggers? | ☐ YES | ☐ NO |
| - Are *aged meats & cheeses, wine, tomatoes,* and *vinegar* triggers? | ☐ YES | ☐ NO |
| - Other triggers: _____ | | |
| Do you experience **hives**? | ☐ YES | ☐ NO |
| Do you get **rashes easily or feel like your skin flushes easily**? | ☐ YES | ☐ NO |
| Do you experience any **brain fog, confusion** or **difficultly thinking**? | ☐ YES | ☐ NO |
| Do you experience any **anal itching or irritation**? | ☐ YES | ☐ NO |
| Do you have **difficultly digesting meat**? | ☐ YES | ☐ NO |
| Do you experience any **fatigue** or **tiredness**? | ☐ YES | ☐ NO |
| Do you notice that you **bruise easily**? | ☐ YES | ☐ NO |
| Do you experience any **fluctuation in mood**? | ☐ YES | ☐ NO |
| Do you experience any **unexpected weight loss** or have **difficulty gaining weight**? | ☐ YES | ☐ NO |

**Oral Health:** Please indicate if any of these symptoms are present.

| | | |
|---|---|---|
| Do you experience **noticeably bad breath even with brushing**? | ☐ YES | ☐ NO |
| Do you **floss** at least 3-4 times a week? | ☐ YES | ☐ NO |
| Do your **gums bleed** frequently? | ☐ YES | ☐ NO |
| Has your dentist mentioned that you have gum **pocket depth** greater than 3mm? | ☐ YES | ☐ NO |
| Do you have a history of **gingivitis** or **multiple dental caries**? | ☐ YES | ☐ NO |

# FUNGUS RELATED DISEASE QUESTIONNAIRE-7 (FRDQ-7)

| Questions: | 0 points | 1 point | 2 points | 3 points |
|---|---|---|---|---|
| Have you, at any time in your life, taken broad spectrum antibiotics? | ☐ NO | - | - | ☐ YES |
| Have you taken tetracycline or other broad spectrum antibiotics for one month or longer? | ☐ NO | - | - | ☐ YES |
| Are your symptoms worse on damp, muggy days or in moldy places? | ☐ NO | - | - | ☐ YES |
| Do you crave sugar? | ☐ NO | - | - | ☐ YES |
| Do you have a feeling of being "drained"? | ☐ None | ☐ Occasional or Mild | ☐ Frequent of moderately severe | ☐ Severe or disabling |
| IF APPLICABLE: Are you bothered with vaginal burning, itching or discharge? OR IF APPLICABLE: Do you have burning, itching or discharge from the penis? | ☐ None | ☐ Occasional or Mild | ☐ Frequent of moderately severe | ☐ Severe or disabling |
| Are you bothered by burning, itching or tearing of your eyes? | ☐ None | ☐ Occasional or Mild | ☐ Frequent of moderately severe | ☐ Severe or disabling |
| **Total points per column: _____ =** _____ + _____ + _____ + _____ | | | | |

**Scoring:** 0-3 = unlikely; 4-9 = probable; 10-21 = almost certain

**Reference:**

Santelmann, Heiko et al. "Effectiveness of nystatin in polysymptomatic patients. A randomized, double-blind trial with nystatin versus placebo in general practice." *Family practice.* 18,3 (2001): 258-65.