# Mold Questionnaire
## MYC Support Protocol

NAME

DATE

| | Never | Occasionally | Often | Regularly |
|---|---|---|---|---|
| Do you see mold growing at home, work, or school? | N | | Y | (10) |
| Have you ever experienced water damage at home, work, or school? | N | | Y | (4) |
| Does your home, work, or school have a damp or mildewy odor? | 0 | 1 | 2 | 3 |
| Does spending time in the basement cause or worsen symptoms? | 0 | 4 | 6 | 8 |
| Is your basement ever wet? | N | | Y | (4) |
| Do symptoms decrease when you spend time in a different location for at least a few days? | N | | Y | (4) |
| Does plumbing in your kitchen or bathroom leak or has it leaked in the past? | N | | Y | (4) |
| Have you seen wet spots anywhere in your home (whether currently or past)? | N | | Y | (4) |
| Do you often see condensation (fog) on the inside of windows and/or cold surfaces in your home? | N | | Y | (4) |
| Does your car have a mildewy smell? | N | | Y | (4) |
| Do you experience brain fog? | 0 | 1 | 2 | 3 |
| Are your reactions to supplements opposite of expected? | 0 | 1 | 2 | 3 |
| Do you experience nosebleeds? | 0 | 1 | 2 | 3 |
| Do you experience body rashes? | 0 | 1 | 2 | 3 |
| Do you have any skin conditions? | N | | Y | (4) |
| Does anyone in your home have asthma-like symptoms? | N | | Y | (4) |
| Do you get sinus infections? | 0 | 1 | 2 | 3 |
| Do one or more family members have chronic sinus infections or irritations? | 0 | 1 | 2 | 3 |
| Do you have a runny, blocked, or stuffy nose? | 0 | 1 | 2 | 3 |
| Do you experience static shocks? | 0 | 1 | 2 | 3 |
| Is there a wheezing or whistling in your chest? | 0 | 1 | 2 | 3 |
| Do you wake up in the morning with a feeling of tightness in your chest? | 0 | 1 | 2 | 3 |
| Do you wake up during the night with shortness of breath? | 0 | 1 | 2 | 3 |
| Do you experience shortness of breath when you're not doing anything strenuous? | 0 | 1 | 2 | 3 |

| | Never | Occasionally | Often | Regularly |
|---|---|---|---|---|
| Do you wake up during the night with a coughing attack? | 0 | 1 | 2 | 3 |
| Do you have chest tightness when around animals or a dusty part of the house? | 0 | 1 | 2 | 3 |
| Are you achy all over? | 0 | 1 | 2 | 3 |
| Do you get headaches? | 0 | 1 | 2 | 3 |
| Do you have extreme or unusual fatigue? | 0 | 1 | 2 | 3 |
| Do you have a hoarse voice? | 0 | 1 | 2 | 3 |
| Do you struggle with memory loss? | 0 | 1 | 2 | 3 |
| Do you have difficulty recalling names of people you know? | 0 | 1 | 2 | 3 |
| Are you sensitive to chemicals and smells? | 0 | 1 | 2 | 3 |
| Are you sensitive to EMFs? | 0 | 1 | 2 | 3 |
| Do you experience bloating or SIBO? | 0 | 1 | 2 | 3 |
| Do you have blurry vision? | 0 | 1 | 2 | 3 |
| Do you have difficulty sleeping or insomnia? | 0 | 1 | 2 | 3 |
| Do you have anxiety or depression? | 0 | 1 | 2 | 3 |
| Do you frequently urinate or are unable to hold your bladder? | 0 | 1 | 2 | 3 |

| GREEN | YELLOW | RED |
|---|---|---|
| 0-19 | 20-68 | 69-138 |

### Instructions

Rate each of the questions to the best of your ability based on the last **90 days**. For Yes/No answers, circle the number provided next to your answer. Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.