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.