

Name of interviewer: _____

Date and time of interview: _____

Interviewee CDC ID number: _____

Ocular Syphilis Interview Form

December 2015

Duration of symptoms prior to diagnosis
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When were you told you had syphilis? (month and year)

Month: _____ Year: ____ _

How many days, weeks or months were there between when you began having eye problems and when you were told you had syphilis?

Days: _____ Weeks: _____ Months: _____

How many days, weeks or months were there between when you first sought care for your eye problems and when you were told you had syphilis?

Days: _____ Weeks: _____ Months: _____

In this time frame, did you see an eye doctor for your eye problems? Yes No

Could you give us the name of the eye doctor or the location of the clinic where you were seen?

Did you see any other doctors for problems related to syphilis? Yes No

Could you give us the name(s) of the doctor(s) or the location(s) of the clinic where you were seen?

Follow-up

What were the first eye problems you noticed?

At any time, did you have any of these problems? I will list several:

Eye pain	Details: _____
Red eye	Details: _____
Blurry vision	Details: _____
Some vision loss	Details: _____
Can't see out of 1 eye	Details: _____
Can't see out of both eyes	Details: _____
Other problems	Details: _____

Do you still have remaining vision problems? Yes No

If NO:

How many days, weeks or months were there between your treatment for syphilis and when your eye problems went away?

Days: _____ Weeks: _____ Months: _____

Other than the medicine you received for syphilis, did you require any additional medicine for your vision problem?

Eye drops: _____

Oral medicine: _____

Intravenous (IV) medicine: _____

If YES:

How many days, weeks or months has it been since you were treated for your syphilis?

Days: _____ Weeks: _____ Months: _____

Have you required any additional medication for your vision problem?

Eye drops: _____

Oral medicine: _____

Intravenous (IV) medicine: _____

Have you had to change any of your normal activities because of vision problems? Yes No

If YES: What sort of changes have been required? _____

In the past month, how much has your eyesight prevented you from doing your normal activities? Would you say:

Not at all or hardly at all A fair amount A substantial amount

Medical and Vision History

Before your recent vision issues, did you wear glasses or contacts? Yes No

Did you visit an eye doctor at least once a year? Yes No

Have you ever taken medicine for an eye or vision related problem before? Yes No

If YES: Please specify: _____

Do you take medicine on a regular basis currently? Yes No

If YES: Please list: _____

Do you take herbal supplements, over the counter medicine or vitamins? Yes No

If YES: Please list: _____

Have you had a friend or relationship partner who has had vision problems potentially related to syphilis?
We won't ask any names. Yes No

Do you have anything else to add? _____