Name of interviewer:		
Date and time of interview: _		
Interviewee CDC ID number:	:	
	Ocular Syphilis Interview Form	
	December 2015	
	Duration of symptoms prior to diag	nosis
When were you told you had	syphilis? (month and year)	
Month:	Year:	
How many days, weeks or motold you had syphilis?	onths were there between when you began ha	aving eye problems and when you were
Days:	Weeks:	Months:
How many days, weeks or mo	onths were there between when you first soug syphilis?	ght care for your eye problems and
Days:	Weeks:	Months:
In this time frame, did you see	e an eye doctor for your eye problems?	Yes No
Could you give us the name o	of the eye doctor or the location of the clinic	where you were seen?
Did you see any other doctors	s for problems related to syphilis?	No
Could you give us the name(s	s) of the doctor(s) or the location(s) of the cli	nic where you were seen?

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

Follo	w-up

What were the first eye problems y	ou noticed?		
At any time, did you have any of the Eye pain Red eye Blurry vision Some vision loss Can't see out of 1 eye Can't see out of both eyes Other problems  Do you still have remaining vision	nese problems? I will list sever Details: Details: Details: Details: Details: Details: Details: Details:	al:	
	If NO:		
How many days, weeks or months went away?	were there between your treati	ment for syphilis and when yo	our eye problems
Days:	Weeks:	Months:	
Oral medicine:	ed for syphilis, did you require :	•	
How many days, weeks or months	has it been since you were trea	ated for your syphilis?	
Days:	Weeks:	Months:	
Oral medicine:	nedication for your vision prob		
Have you had to change any of you		vision problems?	Yes No
In the past month, how much has y	our eyesight prevented you fro	om doing your normal activiti	es? Would you say:
Not at all or hardly at all	A fair amount	A substantial amo	

## **Medical and Vision History**

Before your recent vision issues, did you wear glasses or contacts?	Yes	No 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 potenti We won't ask any names.	ally related to syphili	is?
Do you have anything else to add?		