

Name of interviewer: \_\_\_\_\_

Date and time of interview: \_\_\_\_\_

Interviewee CDC ID number: \_\_\_\_\_

### Ocular Syphilis Interview Form

December 2015

<b>Duration of symptoms prior to diagnosis</b>
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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?

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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? \_\_\_\_\_

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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?** \_\_\_\_\_