Form Approved
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Name of interviewer: _____

Date and time of interview: _____

Interviewee CDC ID number: _____

Ocular Syphilis Interview Form

December 2015

Duration of symptoms prior to diagnosis

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? _____