

## Clinical Care and Health Survey: Patient Opinions

We are interested in **your** opinions and experiences you've had with your doctor or health care provider talking about colon cancer. This may have included a talk about colon cancer screening tests. We would like to know how you feel about talking with your clinician about these issues. **Your** opinions are important to us!

Filling in this survey will help us design programs to help your clinician and others give better patient care. You may be contacted one more time in the future so that we can learn more about the opinions and experiences you've have talking to your doctor about colon cancer.

- ◆ **Selected** patients 50 years old and older who are active members of [this HMO] are being sent this survey. You are being paid \$10 to compensate your for your time and effort.
- ◆ Your answers are strictly **private**
- ◆ Your name is **not** included on your survey
- ◆ Answers from other patients like you will be combined into one final summary
- ◆ Some questions are personal, but provide important information for this study
- ◆ It is **your** choice to skip any questions that you do not want to answer
- ◆ Your doctor will **not** see your answers
- ◆ Filling in this survey can only improve patient care

We thank you **very** much for taking your time to fill in this survey for us. When you are done, please mail it back to us in the enclosed envelope. Thank you!

**CDC LOGO**

**Battelle**  
*The Business of Innovation*  
Centers for Public Health Research and Evaluation  
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This survey has questions that come in different forms. When any question asks about “your clinician”, it means the doctor or medical practitioner who last gave you a routine check-up. You will need to **write in or check (✓)** what **you** think is the **best** answer. **Please see examples below.**

Some questions look like this:

1. What is your age? \_\_\_\_\_
2. Are you: ☐1 Male ☐2 Female?

**You will need to write in or check (✓) the answer.**

Some questions ask you to rate your feelings. Please think about how you feel about each of the topics.

For example, the questions look like this:

**3. How satisfied were you with.....**

|                                                           | Very<br>Dissatisfied     | Dissatisfied                        | Neither<br>Satisfied Nor<br>Dissatisfied | Satisfied                | Very<br>Satisfied        |
|-----------------------------------------------------------|--------------------------|-------------------------------------|------------------------------------------|--------------------------|--------------------------|
| b. the doctor’s explanation of the<br>screening procedure | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/> |

**Please check (✓) the answer that best shows how you feel.**

Some questions ask you to give us your opinions. Please think about if you disagree or agree about each of the statements that you read.

For example, the questions look like this:

|                                                  | Strongly<br>Disagree     | Disagree                 | Neither<br>Agree nor<br>Disagree | Agree                    | Strongly<br>Agree                   |
|--------------------------------------------------|--------------------------|--------------------------|----------------------------------|--------------------------|-------------------------------------|
| C. Men get colon cancer more often than<br>Women | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

**Please check (✓) the answer that best shows how strongly you disagree or agree.**

## PATIENT QUESTIONNAIRE

### *Part I: Tell Us About Yourself*

THIS SECTION ASKS QUESTIONS TO LET US DESCRIBE PATIENTS WHO TAKE PART IN THE SURVEY. PLEASE ANSWER THE FOLLOWING QUESTIONS. PLEASE WRITE OR CHECK (✓) THE BEST ANSWER.

1. What is your age? \_\_\_\_\_
2. What is your sex? ☐ Male ☐ Female
3. Do you consider yourself: (SELECT (✓) ONE)  
☐ Hispanic or Latino  
☐ Not Hispanic or Latino
4. What is your race? (SELECT (✓) ONE OR MORE)  
☐ White  
☐ Black or African American  
☐ Asian  
☐ American Indian or Alaska Native  
☐ Native Hawaiian or Other Pacific Islander
5. What language do you usually speak at home?  
☐ English ☐ Spanish ☐ Other (Please specify) \_\_\_\_\_
6. Are you employed? ☐ Yes ☐ No  
**If Yes:** Is it ☐ Full Time? ☐ Part Time?
7. What was your total family income (before taxes) from ALL income sources in your household in the last year? (PLEASE CHECK (✓) THE ONE THAT IS YOUR BEST GUESS).  

|                                               |                                               |
|-----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Less than \$10,000   | <input type="checkbox"/> \$35,000 to \$49,000 |
| <input type="checkbox"/> \$10,000 to \$19,000 | <input type="checkbox"/> \$50,000 to \$74,000 |
| <input type="checkbox"/> \$20,000 to \$34,000 | <input type="checkbox"/> \$75,000 +           |
| <input type="checkbox"/> Don't know           |                                               |
8. What is the highest grade or year of school you finished?  
☐ Didn't go to school  
☐ Grade School (1-5 years)  
☐ Middle school (6-8 years)  
☐ Some High School (9-11 years)  
☐ High school diploma or G.E.D.  
☐ Vocational or training school  
☐ Some college or Associate Arts Degree  
☐ College graduate with BA or BS Degree  
☐ Graduate/professional education and/or Degree

NOW WE WOULD LIKE TO ASK YOU ABOUT YOUR RELATIONSHIP WITH YOUR DOCTOR. PLEASE WRITE IN OR CHECK (✓) THE BEST ANSWER. IF A QUESTION ASKS ABOUT "THIS DOCTOR", IT MEANS THE DOCTOR OR CLINICIAN WHO GAVE YOU YOUR ANNUAL CHECK-UP (I.E., ANNUAL EXAM, YEARLY PHYSICAL EXAM).

9. How long have you been a patient with the doctor who did your last annual check-up?  
\_\_\_\_\_
10. How would you describe how often you have seen this doctor?  
(PLEASE CHECK (✓) ALL THAT APPLY).
- ☐ I am a new patient of this doctor and I have only visited once or twice.
  - ☐ I get most of my care from this doctor.
  - ☐ This doctor does most of my annual check-ups.
  - ☐ I get most of my care from another doctor or nurse in this doctor's office.
  - ☐ I get most of my care from another doctor's or nurse's office.
  - ☐ Other (Please specify) \_\_\_\_\_
11. How many times in the past year have you seen this doctor? \_\_\_\_\_
12. Which type of health coverage do you have in your health plan? (CHECK (✓) ALL THAT APPLY)
- ☐ Co-pay less than or equal to \$10 for all clinic visits
  - ☐ Co-pay between \$10 and \$20 for all clinic visits
  - ☐ Free (no cost) annual exam visit
  - ☐ Co-pay for annual exam visit
  - ☐ Free (no cost) preventive services (screening for cholesterol, blood sugar, cervical cancer, colorectal cancer, breast cancer, prostate cancer)
  - ☐ Co-pay for all preventive services (screening for cholesterol, blood sugar, cervical cancer, colorectal cancer, breast cancer, prostate)

**Part II: Personal Cancer Experience and  
Family History of Colon Cancer**

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT COLON CANCER. WHEN WE USE THE TERM COLON CANCER, WE MEAN CANCER OF THE COLON, RECTUM, OR BOWEL. YOU MAY ALSO HAVE HEARD THE TERM COLORECTAL CANCER. PLEASE WRITE IN OR CHECK (✓) THE BEST ANSWER.

1. How likely do you think you are to develop colon cancer sometime in your life?

Would you say it is...

☐ Extremely unlikely   ☐ Unlikely   ☐ Neither likely or unlikely   ☐ Likely   ☐ Extremely likely

2. Compared to other people your age how would you rate your own risk of getting colon cancer?

☐ Much lower   ☐ Lower   ☐ About the same   ☐ Higher   ☐ Much higher

3. In general, would you say that your health is....

☐ Excellent   ☐ Very good   ☐ Good   ☐ Fair   ☐ Poor

4. Have you ever been diagnosed with cancer?

☐ Yes   ☐ No (**GO TO QUESTION 5**)

If 'Yes', what type of cancer? \_\_\_\_\_

5. Has anyone in your immediate family (i.e., spouse, children, parents, siblings) ever been diagnosed with cancer?

☐ Yes   ☐ No or Don't Know (**GO TO PART III, QUESTION 1**)

If 'Yes', please list your immediate family members who have had cancer and the type of cancer. List up to 5 family members.

| Family Member | Type of Cancer |
|---------------|----------------|
| 1. _____      | _____          |
| 2. _____      | _____          |
| 3. _____      | _____          |
| 4. _____      | _____          |
| 5. _____      | _____          |

### *Part III: Experience with Tests and Screenings*

NOW WE ARE INTERESTED IN YOUR EXPERIENCE WITH COLORECTAL CANCER SCREENING OR TESTING. PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT COLON CANCER AND COLON CANCER SCREENING TESTS.

1. Have you ever had any bowel symptoms (i.e., blood in the stool, changes in bowel movements) that prompted your doctor to suggest you be tested for colon cancer?

☐ Yes ☐ No

2. Have you **heard of** the following tests for colon cancer?

|                                                                    | Yes                      | No                       |
|--------------------------------------------------------------------|--------------------------|--------------------------|
| Digital rectal exam                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Fecal occult blood test (FOBT) or Hemoccult test (stool card test) | <input type="checkbox"/> | <input type="checkbox"/> |
| Flexible sigmoidoscopy                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Colonoscopy                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Barium enema                                                       | <input type="checkbox"/> | <input type="checkbox"/> |

3. How worthwhile do you think the following tests are for detecting colon cancer early?  
(PLEASE MARK "DON'T KNOW" IF YOU HAVE NEVER HEARD OF THE TEST)

|                                                               | Not at all<br>worthwhile | Slightly<br>worthwhile   | Somewhat<br>worthwhile   | Quite<br>worthwhile      | Very<br>worthwhile       | Don' t<br>Know           |
|---------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Digital rectal exam                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fecal occult blood test (FOBT) or Hemoccult (stool card test) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Flexible sigmoidoscopy                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Colonoscopy                                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Barium enema                                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

4. Please check (✓) below if your doctor did or ordered the following tests at your last check-up AND / OR some other time in the last five years.

| Tests ordered:                                                        | Done or Ordered at<br>last Check-up? ✓ answer |                          | Done or Ordered in the<br>last 5 years? ✓ answer |                          |
|-----------------------------------------------------------------------|-----------------------------------------------|--------------------------|--------------------------------------------------|--------------------------|
|                                                                       | Yes                                           | No                       | Yes                                              | No                       |
| <b>Blood pressure</b>                                                 | <input type="checkbox"/>                      | <input type="checkbox"/> | <input type="checkbox"/>                         | <input type="checkbox"/> |
| <b>Cholesterol test (blood test)</b>                                  | <input type="checkbox"/>                      | <input type="checkbox"/> | <input type="checkbox"/>                         | <input type="checkbox"/> |
| <b>Digital rectal exam for colon cancer (i.e.,<br/>'finger' test)</b> | <input type="checkbox"/>                      | <input type="checkbox"/> | <input type="checkbox"/>                         | <input type="checkbox"/> |
| <b>FOBT (stool card test)</b>                                         | <input type="checkbox"/>                      | <input type="checkbox"/> | <input type="checkbox"/>                         | <input type="checkbox"/> |
| <b>Flexible sigmoidoscopy</b>                                         | <input type="checkbox"/>                      | <input type="checkbox"/> | <input type="checkbox"/>                         | <input type="checkbox"/> |
| <b>Colonoscopy</b>                                                    | <input type="checkbox"/>                      | <input type="checkbox"/> | <input type="checkbox"/>                         | <input type="checkbox"/> |
| <b>For Women:</b>                                                     |                                               |                          |                                                  |                          |
| <b>Pap smear</b>                                                      | <input type="checkbox"/>                      | <input type="checkbox"/> | <input type="checkbox"/>                         | <input type="checkbox"/> |
| <b>Breast exam</b>                                                    | <input type="checkbox"/>                      | <input type="checkbox"/> | <input type="checkbox"/>                         | <input type="checkbox"/> |
| <b>Mammogram (breast x-ray)</b>                                       | <input type="checkbox"/>                      | <input type="checkbox"/> | <input type="checkbox"/>                         | <input type="checkbox"/> |
| <b>For Men:</b>                                                       |                                               |                          |                                                  |                          |
| <b>Prostate specific antigen blood test<br/>(PSA)</b>                 | <input type="checkbox"/>                      | <input type="checkbox"/> | <input type="checkbox"/>                         | <input type="checkbox"/> |

5. Please check (✓) below if your doctor talked to you about each issue at your last check-up AND / OR anytime in the last five years.

| Did your doctor talk to you<br>about: | Talked about at last check-<br>up? |                          |                          | Talked about in the<br>last 5 years? |                          |                          | IF TALKED ABOUT:<br>Who brought the<br>subject up? |                          |                          |
|---------------------------------------|------------------------------------|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|----------------------------------------------------|--------------------------|--------------------------|
|                                       | Yes                                | No                       | NA                       | Yes                                  | No                       | NA                       | Me                                                 | Doctor                   | NA                       |
| Smoking                               | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise or physical activity         | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Your dietary practices                | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Breast cancer screening               | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Cervical cancer screening             | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Prostate cancer screening             | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Colorectal cancer screening           | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Fecal occult blood test<br>(FOBT)     | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Flexible sigmoidoscopy                | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                           | <input type="checkbox"/> | <input type="checkbox"/> |

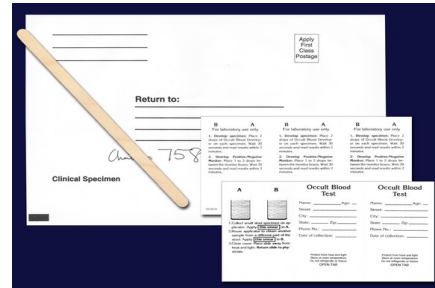
Colonoscopy



## Part IV: Colon Cancer Screening Experience

NOW WE ARE INTERESTED IN YOUR EXPERIENCE WITH EITHER FOBT, FLEXIBLE SIGMOIDOSCOPY OR COLONOSCOPY.

***FOBT stands for a Fecal Occult Blood Test which is a set of cards to take home to collect a stool sample. Then you mail in or return the cards to be tested for hidden blood in the stool. (Sometimes called Hemoccult test or stool card test)***



***Flexible Sigmoidoscopy is also called a 'Flex Sig'. It is when a doctor or nurse practitioner inserts a flexible tube into your rectum (or bottom) to check for bowel problems and colon cancer.***



***A Colonoscopy is a medical procedure which you will have in a clinic or hospital setting. It allows a full viewing of the colon. You will have preparation that you will do, and during the procedure you will be given a sedative. A doctor inserts a flexible tube into your rectum (or bottom) to check for bowel problems and colon cancer.***

1. Please check whether and when you have had each of the following colon cancer screening tests. (PLEASE CHECK (✓) ONLY ONE BOX FOR EACH TEST).

|              | Never had screening      | Less than 6 months ago   | 6 months to a year ago   | 1-2 years ago            | 3-5 years ago            | 6-10 years ago           | More than 10 years ago   |
|--------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| FOBT         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Flex Sig     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Colonoscopy  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Barium Enema | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

*Fecal Occult Blood Test (FOBT)*

2. ***Have you been given an FOBT kit to take home in the last year?***

☐ Yes ☐ No ➔ (If NO, GO TO QUESTION 9)  
 ↓

3. ***Were you given instructions on how to use the FOBT cards?***

☐ Yes ☐ No

4. ***Were you reminded to return the cards?***

☐ Yes ☐ No

5. ***Did you return the cards?***

☐ Yes ☐ No If No, Why not?

6. Did you get the results? ☐ Yes ☐ No

7. ***How did you get the results?***

Phone call from: ☐ physician ☐ nurse ☐ medical assistant

Letter from: ☐ physician ☐ clinic ☐ lab

8. PLEASE CHECK (✓) THE BEST ANSWER BELOW:

| How satisfied were you with.....                                     | Very<br>Dissatisfied     | Dissatisfied             | Neither<br>Satisfied nor<br>Dissatisfied | Satisfied                | Very<br>Satisfied        |
|----------------------------------------------------------------------|--------------------------|--------------------------|------------------------------------------|--------------------------|--------------------------|
| a. Colon cancer information given by<br>your doctor's office         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/> |
| b. The doctor's explanation of the<br>procedures to do the FOBT test | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Dietary restrictions                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Overall preparations for the FOBT                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Collection of the stool sample                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Reminder procedures                                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Follow-up procedures                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Explanation of the FOBT test results                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Receiving the FOBT test results                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/> |

*Flexible Sigmoidoscopy (Flex Sig)* (Please see the definition on page 6)

9. **In the past 5 years did your doctor recommend a Flex Sig test?**

☐ Yes ☐ No ➔ (If No, GO TO QUESTION 14)



10. **Did you schedule an appointment?**

☐ Yes ☐ No If No, Why not?

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11. **Did you have the test?**

☐ Yes ☐ No If No, Why not?

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12. Did you get the results? ☐ Yes ☐ No

13. **PLEASE CHECK (✓) THE BEST ANSWER BELOW:**

| <b>Flex Sig</b>                                            |                              |                          |                                                   |                          |                           |
|------------------------------------------------------------|------------------------------|--------------------------|---------------------------------------------------|--------------------------|---------------------------|
| <b>How satisfied were you with.....</b>                    | <b>Very<br/>Dissatisfied</b> | <b>Dissatisfied</b>      | <b>Neither<br/>Satisfied nor<br/>Dissatisfied</b> | <b>Satisfied</b>         | <b>Very<br/>Satisfied</b> |
| a. Colon cancer information given by your doctor           | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/>                          | <input type="checkbox"/> | <input type="checkbox"/>  |
| b. The doctor's explanation of the Flex Sig screening test | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/>                          | <input type="checkbox"/> | <input type="checkbox"/>  |
| c. Dietary restrictions                                    | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/>                          | <input type="checkbox"/> | <input type="checkbox"/>  |
| d. The use of an enema or laxatives                        | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/>                          | <input type="checkbox"/> | <input type="checkbox"/>  |
| e. Overall preparations for the Flex Sig                   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/>                          | <input type="checkbox"/> | <input type="checkbox"/>  |
| f. The convenience of the screening location               | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/>                          | <input type="checkbox"/> | <input type="checkbox"/>  |
| g. How the screening technician treated me                 | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/>                          | <input type="checkbox"/> | <input type="checkbox"/>  |
| h. The level of discomfort during the Flex Sig procedure   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/>                          | <input type="checkbox"/> | <input type="checkbox"/>  |
| i. Follow-up procedures                                    | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/>                          | <input type="checkbox"/> | <input type="checkbox"/>  |
| j. Explanation of the Flex Sig test results                | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/>                          | <input type="checkbox"/> | <input type="checkbox"/>  |



Colonoscopy (Please see the definition on page 6)

14. In the past 10 years did your doctor recommend a Colonoscopy test?

☐ Yes ☐ No ➡ (If NO, SKIP TO NEXT SECTION)



15. Did you schedule an appointment?

☐ Yes ☐ No If No, Why not?

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16. Did you have the test?

☐ Yes ☐ No If No, Why not?

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17. Did you get the results? ☐ Yes ☐ No

18. PLEASE CHECK (✓) THE BEST ANSWER BELOW:

| How satisfied were you with.....                              | Very<br>Dissatisfied     | Dissatisfied             | Neither<br>Satisfied nor<br>Dissatisfied | Satisfied                | Very<br>Satisfied        |
|---------------------------------------------------------------|--------------------------|--------------------------|------------------------------------------|--------------------------|--------------------------|
| a. Colon cancer information given by your doctor              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/> |
| b. The doctor's explanation of the Colonoscopy screening test | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Dietary restrictions                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/> |
| d. The use of an enema or laxatives                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Overall preparations for the Colonoscopy                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/> |
| f. The convenience of the screening location                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/> |
| g. How the screening technician treated me                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/> |
| h. The level of discomfort during the Colonoscopy procedure   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Follow-up procedures                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/> |



### Part V: Colon Cancer Knowledge

1. For each of the following statements please check if you “disagree”, “agree” or are “not sure”.

|                                                                                                                         | Disagree                 | Agree                    | Not Sure                 |
|-------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| a. Eating foods high in fat increases your risk of developing colon cancer.                                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Your chances of getting colon cancer are greater if you have a family member who had colon cancer.                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Men get colon cancer more often than women.                                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. If a person gets colon cancer, it cannot be cured.                                                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Blood in your stool means you have cancer for sure.                                                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. A diet with a lot of roughage, like fruits, vegetables, and grains, may reduce your chances of getting colon cancer. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. You should have your stool tested for hidden blood every year if you are 50 years or older.                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

### Part VI: Your Opinions

PLEASE CHECK (✓) HOW STRONGLY YOU DISAGREE OR AGREE WITH EACH OPINION BELOW.

1. Discussing colon cancer screening with my doctor:

|                                                                                    | Strongly Disagree        | Disagree                 | Neither Agree nor Disagree | Agree                    | Strongly Agree           |
|------------------------------------------------------------------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|
| a. is not necessary because of my age.                                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. is hard to do because my doctor doesn't think it is important.                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. is not as important as talking about other health problems I have.              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. is only needed if I have symptoms.                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. would just mean that I would have to have more unnecessary tests done.          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. is not needed because my doctor has already covered all the issues with me.     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| g. would take too much time.                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| h. would make me uncomfortable.                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| i. is something the doctor won't talk about because my insurance doesn't cover it. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| j. is hard to do because my doctor is not easy to talk to.                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| k. is a waste of time because when I ask                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |

questions, the doctor doesn't have answers.

- l. would be embarrassing. ☐ ☐ ☐ ☐ ☐

WHETHER OR NOT YOU HAVE BEEN GIVEN AN FOBT KIT TO TAKE HOME, YOUR  
OPINIONS ARE IMPORTANT TO US.

PLEASE CHECK (✓) HOW STRONGLY YOU DISAGREE OR AGREE WITH EACH OPINION  
BELOW.

2. Having an FOBT (fecal occult blood test):

|                                                                              | Strongly<br>Disagree     | Disagree                 | Neither<br>Agree nor<br>Disagree | Agree                    | Strongly<br>Agree        |
|------------------------------------------------------------------------------|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|
| a. is needed only if I have symptoms.                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| b. is needed only if there is a family history<br>of colon cancer.           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| c. is not needed if I eat a healthy diet.                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| d. would only detect cancer after it is too<br>late.                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| e. would give me a feeling of control over<br>my health.                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| f. is something I am too busy to do.                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| g. would protect my health so I can take<br>better care of my family.        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| h. is not as important as screening tests for<br>other diseases and cancers. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| i. is not necessary at my age.                                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| j. would be awful (disgusting) because I<br>have to handle my stool.         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| k. is a test I like being able to do in the<br>privacy of my own home.       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| l. is not needed if I've had it once before.                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| m. involves too much hassle because I have<br>to prepare for the test.       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| n. is something I don't know how to do<br>correctly.                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| o. is a waste of time because the test is not<br>accurate.                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| p. is unnecessary for women because only<br>men are at risk for colon cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |

WHETHER OR NOT YOU HAVE HAD A FLEX SIG, YOUR OPINIONS ARE IMPORTANT TO US.

PLEASE CHECK (✓) HOW STRONGLY YOU DISAGREE OR AGREE WITH EACH OPINION BELOW.

3. Having a Flex Sig (Flexible Sigmoidoscopy) test:

|                                                                                                     | Strongly<br>Disagree     | Disagree                 | Neither<br>Agree nor<br>Disagree | Agree                    | Strongly<br>Agree        |
|-----------------------------------------------------------------------------------------------------|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|
| a. is needed only if there is a family history of colon cancer                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| b. can prevent me from getting colon cancer by finding and removing polyps that could become cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| c. is unnecessary if I have an FOBT                                                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| d. is unnecessary if I have a Colonoscopy                                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| e. is <u>not</u> needed if I eat a healthy diet                                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| f. would only detect cancer after it is too late                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| g. would give me a feeling of control over my health                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| h. is something I am too busy to do                                                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| i. would protect my health so I can take better care of family                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| j. is not as important as screening tests for other diseases and cancers                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| k. is a hassle because the wait for the appointment is too long                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| l. is not necessary at my age                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| m. would be embarrassing                                                                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| n. would be stressful (frightening, scary)                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| o. would be uncomfortable                                                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| p. is not needed if I've had it once before                                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| q. involves too much hassle because I have to prepare for the test                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| r. is unnecessary for women because only men are at risk for colon cancer                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |

WHETHER OR NOT YOU HAVE HAD A COLONOSCOPY, YOUR OPINIONS ARE IMPORTANT TO US.

PLEASE CHECK (✓) HOW STRONGLY YOU DISAGREE OR AGREE WITH EACH OPINION BELOW.

4. Having a Colonoscopy test:

|                                                                                                     | Strongly<br>Disagree     | Disagree                 | Neither<br>Agree nor<br>Disagree | Agree                    | Strongly<br>Agree        |
|-----------------------------------------------------------------------------------------------------|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|
| a. is needed only if there is a family history of colon cancer                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| b. can prevent me from getting colon cancer by finding and removing polyps that could become cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| c. is unnecessary if I have an FOBT                                                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| d. is unnecessary if I have a Flex Sig                                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| e. is not needed if I eat a healthy diet                                                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| f. would only detect cancer after it is too late                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| g. would give me a feeling of control over my health                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| h. is something I am too busy to do.                                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| i. would protect my health so I can take better care of family                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| j. is not as important as screening tests for other diseases and cancers                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| k. is a hassle because the wait for the appointment is too long                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| l. is not necessary at my age                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| m. would be embarrassing                                                                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| n. would be stressful (frightening, scary)                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| o. would be uncomfortable                                                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| p. is not needed if I've had it once before                                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| q. involves too much hassle because I have to prepare for the test                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| r. is unnecessary for women because only men are at risk for colon cancer                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |

WHETHER OR NOT YOU HAVE BEEN GIVEN AN FOBT KIT TO TAKE HOME OR HAD A FLEX SIG OR COLONOSCOPY, YOUR OPINIONS ARE IMPORTANT TO US.

5. Please check how strongly you disagree or agree with each opinion below:

|                                                                           | Strongly<br>Disagree     | Disagree                 | Neither<br>Agree nor<br>Disagree | Agree                    | Strongly<br>Agree        |
|---------------------------------------------------------------------------|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|
| a. Fitting a flex sig screening test into my schedule is hard             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I have trouble taking time off from work to do the flex sig test       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Fitting a colonoscopy screening test into my schedule is hard          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I have trouble taking time off from work to do the colonoscopy test    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Colon cancer screening is a way for doctors and insurers to make money | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Medicare pays for flex sig screening                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Medicare pays for colonoscopy screening                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| h. My insurance or health plan pays for flex sig screening                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| i. My insurance or health plan pays for colonoscopy screening             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| j. I would do the FOBT kit if my doctor tells me to                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| k. I would do the flex sig if my doctor tells me to                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| l. I would do the colonoscopy if my doctor tells me to                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| m. My doctor never talks about colon cancer screening                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| n. My doctor never talks about FOBT                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| o. My doctor never talks about flex sig                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| p. My doctor never talks about colonoscopy                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |

## Part VII: Social Support

PLEASE CHECK (✓) HOW STRONGLY YOU DISAGREE OR AGREE WITH EACH OPINION BELOW.

**1. *Discussing colorectal cancer screening with my doctor (the one who did my last check-up) is something that is encouraged by:***

|                                             | Strongly Disagree        | Disagree                 | Neither Agree nor Disagree | Agree                    | Strongly Agree           |
|---------------------------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|
| a. my spouse or partner                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. my family                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. my friends                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. my doctor or nurse                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. the popular media (TV, radio, magazines) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |

**2. *My having an FOBT is something that is encouraged by:***

|                                             | Strongly Disagree        | Disagree                 | Neither Agree nor Disagree | Agree                    | Strongly Agree           |
|---------------------------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|
| a. my spouse or partner                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. my family                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. my friends                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. my doctor or nurse                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. the popular media (TV, radio, magazines) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |

**3. *My having a screening flex sig is something that is encouraged by:***

|                                             | Strongly Disagree        | Disagree                 | Neither Agree nor Disagree | Agree                    | Strongly Agree           |
|---------------------------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|
| a. my spouse or partner                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. my family                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. my friends                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. my doctor or nurse                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. the popular media (TV, radio, magazines) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |

**4. *My having a screening colonoscopy is something that is encouraged by:***

|                         | Strongly Disagree        | Disagree                 | Neither Agree nor Disagree | Agree                    | Strongly Agree           |
|-------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|
| a. my spouse or partner | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. my family            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. my friends           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |

- |                                             |                          |                          |                          |                          |                          |
|---------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| d. my doctor or nurse                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. the popular media (TV, radio, magazines) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

### Part VIII: Plans to Talk About Colon Cancer or Get Screened

PLEASE CHECK (✓) HOW STRONGLY YOU DISAGREE OR AGREE WITH EACH OPINION BELOW.

1. *Please answer the following questions about cancer screening:*

|                                                                                 | Strongly<br>Disagree     | Disagree                 | Neither<br>Agree nor<br>Disagree | Agree                    | Strongly<br>Agree        |
|---------------------------------------------------------------------------------|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|
| a. I plan to discuss colon cancer screening with my doctor at my next check-up. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I plan to do an FOBT after my next check-up.                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I plan to have a flexible sigmoidoscopy after my next check-up.              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I plan have a colonoscopy after my next check-up.                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |

**THE END**

**THANK YOU VERY MUCH FOR COMPLETING YOUR SURVEY**

Please place it in the enclosed, stamped, envelope and drop it in the mail for us!