

Patient Post-Intervention Survey

## ~~Clinical Care and Health Survey:~~ ~~Patient Opinions~~

### *Screening and Prevention Survey*

*Funded by  
The Centers for Disease Control and Prevention  
Atlanta, GA*

We are interested in **your** ~~your~~ opinions and experiences ~~you've had~~ when talking with your doctor or health care provider talking about colon cancer screening. *Even if you have not talked to your doctor or provider about colon cancer screening, or even if you have not been screened, please still fill out this survey.* ~~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** Your opinions are important to us!

~~Filling in~~ *Completing* this survey will help us ~~design~~ *make* programs to help ~~your~~ *clinician* provider 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. You may have received a similar survey about colon cancer screening in the past. Please complete this new survey whether or not you filled out a similar one a few months ago.~~

- ◆ You were **selected** to receive this survey because you are age patients 50 years old and or older who are active members and you visited an [HMO] clinic in the past 3 months of [this HMO] are being sent this survey. You are being paid \$10 to compensate you for your time and effort.
- ◆ Your answers are strictly **private**
- ◆ ~~Your name is not included~~ *Please do not put your name 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.
- ◆ *Please also mail your signed HIPPA form which allows us to include your survey answers in our final summary [ABQ HP/Lovelace participants only]*

~~CDC LOGO~~

**Thank you!**

**Battelle**

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

Some questions look like this:

A1. What is your age? \_\_\_\_\_

A2. Are you *male or female*? ~~1 Male 2 Female~~       Male  
     Female

**You will need to write in your age or check (✓) the answer the box for male or female.**

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:

A3. How satisfied were you with.....

	Very Dissatisfied	Dissatisfied	Neither Satisfied Nor Dissatisfied	Satisfied	Very Satisfied
a. the doctor’s explanation of the screening procedure	<input type="checkbox"/>	— <input checked="" type="checkbox"/>	<input 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 Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
c. Men get colon cancer more often than Women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/>

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

PATIENT QUESTIONNAIRE

**Part I SECTION A: 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 *IN* OR CHECK (✓) THE BEST ANSWER.

- A1. What is your age? \_\_\_\_\_
- A2. What is your sex?  Male  
 Female
- A3. Do you consider yourself: (~~SELECT PLEASE~~ ✓ ONLY ONE)  
 Hispanic or Latino  
 Not Hispanic or Latino
- A4. What is your race? (*PLEASE* ✓ ONE OR MORE)  
 White  
 Black or African American  
 Asian  
 American Indian or Alaska Native  
 Native Hawaiian or Other Pacific Islander
- A5. What language do you usually speak at home?  
 English  Spanish  Other (Please specify) \_\_\_\_\_
- A6. What is the highest grade or year of school you finished? (formerly was #8)  
 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
- A7. Are you employed?  Yes (*If Yes, please answer Question A7a*)  
 No (*If No, please go to Question A8*)  
  
—~~If Yes:~~ A7a: Are you employed full time or part time: Is it  Full Time  
 Part Time
- A8. 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).  
 Less than \$10,000  
 \$10,000 to \$19,000  
 \$20,000 to \$34,000

- \$35,000 to \$49,000
- \$50,000 to \$74,000
  
- \$75,000 +
- Don't know

~~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).~~

~~NEXT ARE SOME QUESTIONS ABOUT THE PRIMARY CARE PROVIDER YOU MOSTG RECENTLY SAW.~~

~~A9. How long have you been a patient with the doctor who did your last annual check-up the primary care provider you most recently saw? \_\_\_\_\_ Years \_\_\_\_\_ Months~~

~~A10. How would you describe How often you have seen this doctor provider?  
(PLEASE CHECK ✓ ALL THAT APPLY).~~

- I am a new patient of this doctor provider and I have only visited once or twice.
- I get most of my care from this doctor provider.
- This doctor provider does most of my annual check-ups.
- I get most of my care from another doctor or nurse provider in this doctor's the same office.
- I get most of my care from another doctor's or nurse's provider'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 SECTION B: Experience with Tests and Screenings**

NOW WE ARE INTERESTED IN YOUR EXPERIENCE ~~WITH COLORECTAL CANCER SCREENING OR TESTING~~ TALKING WITH YOUR PRIMARY CARE PROVIDER ABOUT DISEASE PREVENTION AND HAVING DIFFERENT SCREENING TESTS, INCLUDING COLON CANCER SCREENING. WHEN WE USE THE TERM COLON CANCER, WE MEAN CANCER OF THE COLON, RECTUM OR BOWEL. IT IS SOMETIMES CALLED COLORECTAL CANCER. PLEASE ANSWER THE FOLLOWING QUESTIONS. ~~ABOUT COLON CANCER AND COLON CANCER SCREENING TESTS.~~

B1. Have you ever had any bowel symptoms (i.e., blood in the stool, changes in bowel movements) that ~~prompted~~ caused your ~~doctor~~ provider to suggest you be tested for colon cancer?

- Yes  No

[Now question # 3]

B2. Have you **heard of** the following tests for colon cancer?

	Yes	No
a. <del>Digital rectal exam</del> Rectal exam "finger test"	<input type="checkbox"/>	<input type="checkbox"/>
b. Fecal occult blood test (FOBT) or Hemocult test (stool card test)	<input type="checkbox"/>	<input type="checkbox"/>
c. Fecal Immunochemical Test (FIT)	<input type="checkbox"/>	<input type="checkbox"/>
d. Flexible sigmoidoscopy	<input type="checkbox"/>	<input type="checkbox"/>
e. Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>
f. Virtual colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>
g. Barium enema	<input type="checkbox"/>	<input type="checkbox"/>

[Now question #4]

B3. 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 worthwhile	Slightly worthwhile	Somewhat worthwhile	Quite worthwhile	Very worthwhile	Don' t Know
a. <del>Digital rectal exam</del> Rectal exam "finger test"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Fecal occult blood test (FOBT) or Hemocult (stool card test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Fecal Immunochemical Test (FIT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Flexible sigmoidoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- |                               |                          |                          |                          |                          |                          |                          |
|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| e. Colonoscopy                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. <i>Virtual colonoscopy</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Barium enema               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

[Now question #5)



**B4. Please check (✓) below if your ~~doctor~~ primary care provider did or ordered the following tests at your last check-up AND / OR some other time in the last five years.**

Tests ordered Did your provider order any of the following tests?:	Done or Ordered at last Check-up Visit? ✓ answer		Done or Ordered in the last 5 years? ✓ answer	
	Yes	No	Yes	No
a. Blood pressure check	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Cholesterol test (blood test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. <del>Digital</del> Rectal exam for colon cancer (i.e., 'finger' test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. FOBT (stool card test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Flexible sigmoidoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For Women:				
g. Pap smear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Breast exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Mammogram (breast x-ray)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For Men:				
j. Prostate specific antigen blood test (PSA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

[Now question #2)

**B5. Please check (✓) below if your ~~doctor~~ provider talked to you about each issue at your last check-up AND / OR anytime in the last five years.**

Did your <del>doctor</del> provider talk to you about:	Talked about at last check-up?			Talked about in the last 5 years?			IF TALKED ABOUT: Who brought the subject up?		
	Yes	No	NA	Yes	No	NA	Me	Doctor	NA
a. 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"/>
b. 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"/>
c. <del>Your dietary practices</del> Dietary and nutritional habits	<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"/>
d. Colon 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"/>

	<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"/>
For Women:									
e. Breast Cancer Screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
f. Cervical cancer screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
For Men:	<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									
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 (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	<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"/>

[NOW QUESTION #1)

**Section C: Personal Cancer Experience and Family History of Colon Cancer**

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT COLON CANCER. TO ANSWER THE FOLLOWING QUESTIONS, PLEASE WRITE IN OR CHECK (✓) THE BEST ANSWER.

C1. In general, would you say that your health is...

- Excellent
- Very good
- Good
- Fair
- Poor

C2. Have you ever been diagnosed with cancer?  Yes (if Yes, please answer Question C2a)

No (If No, please answer Question C3)

C2a. What type of cancer? (Please specify): \_\_\_\_\_

C3. Has anyone in your immediate family (i.e., spouse, children, parents, siblings) ever been diagnosed with cancer?

- Yes
- No
- Don't Know

C4. Has anyone in your immediate family (i.e., spouse, children, parents, siblings) ever been diagnosed with **colon** cancer?

- Yes
- No
- Don't Know

C5. 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

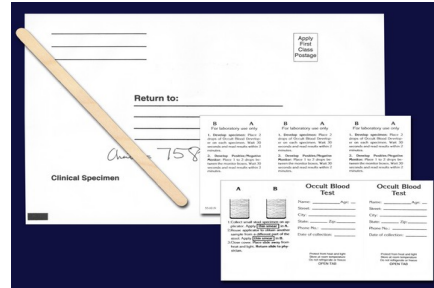
C6. Compared to other people your age how would you rate your own risk of getting colon cancer?

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

**Part IV SECTION D: Colon Cancer Screening Experience**

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

**FOBT stands for a Fecal Occult Blood Test which is a set of cards to take home to collect 3 stool samples. 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. You have a preparation that you do at home, The Flex Sig is done in a clinic without a sedative. You have to have someone to drive you home, and you may have to miss work for the day.**





*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:~~

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

*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:

Flex Sig How satisfied were you with.....	Very Dissatisfied	Dissatisfied	Neither Satisfied nor Dissatisfied	Satisfied	Very 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 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?  
\_\_\_\_\_  
\_\_\_\_\_

16. Did you have the test?

Yes  No If No, Why not?  
\_\_\_\_\_  
\_\_\_\_\_

17. Did you get the results?  Yes  No

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

How satisfied were you with.....	Very Dissatisfied	Dissatisfied	Neither Satisfied nor Dissatisfied	Satisfied	Very 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"/>





NOTE: Following questions D3 through D8 related to patient's experience with CRC screening at his/her last PC visit, are old (modified) questions, which in the original survey were in Part IX. In the new survey the whole part IX is deleted (see above), and these few questions have been moved to this section. Number of items and information to be gathered remains the same, with no impact on purpose, scope or anticipated analyses.

Now we are interested in your **experience with colon cancer screening** at your last primary care visit and in the past few years.

- D3. Did you receive any information about colorectal cancer screening in the mail, before your last primary care visit?
- Yes (Continue)  
 No (IF NO, GO TO QUESTION D6)
- D4. Did you read through the information about colorectal cancer screening before your appointment?
- Yes  
 No
- D5. Did you find the information about colon cancer screening to be helpful?
- Yes  
 No
- D6. Did you and your provider talk about colon cancer screening at your last primary care visit?
- Yes (Continue)  
 No (If No, please go to Question D9)
- D7. Who started the conversation about colon cancer screening at your last primary care visit? **Please ✓ only one.**
- You  
 Your provider  
 One of clinic staff

D8. Please check how strongly you agree or disagree with the statements about your **colon cancer screening discussion** at your last primary care visit.

- a. I felt that colon cancer screening was
- |  |                          |                          |                            |                          |                          |
|--|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|
|  | Strongly Disagree        | Disagree                 | Neither Agree nor Disagree | Agree                    | Strongly Agree           |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
important for me.					
b. My provider listened carefully to what I had to say about colon cancer screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. My provider answered all my questions about colon cancer screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I felt that colon screening could prevent colorectal cancer.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I felt understood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I felt comfortable expressing my feelings about colon cancer screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. My provider acted like I was wasting his or her time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. I felt comfortable asking questions about colon cancer screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. I felt pressured to get screened	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. I wanted the conversation to end	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. At the end of the discussion I wanted to get screened for colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Fecal Occult Blood Test (FOBT) (Please see the description on page X.)**

- D9. At your last primary care visit, did your provider talk with you about colon cancer screening with an FOBT kit?  Yes (Continue)  No (If No, please go to Question D12)
- D10. At your last primary care visit, did your provider recommend that you get screened with an FOBT kit?  Yes (Continue)  No (If No, please go to Question D12)
- D11. At your last primary care visit, were you given an FOBT kit to take home?  Yes (If Yes, please go to Question D13)  No (Continue)

D12. In the last year, were you given an FOBT kit to take home?

- Yes (Continue)

No (IF NO, GO TO QUESTION D20)

D13. When you were given the kit, did someone at your provider's office give you instructions on how to use the FOBT cards?

- Yes
- No

D14. After you got home, did someone from your provider's office remind you to return the cards?

- Yes
- No

D16. Did you return the FOBT cards?

- Yes (Continue)
  - No (If No, please go to Question D20)
- 

D17. How did you get the results?

- Phone call from the provider's office
- Letter from the provider's office
- In person
- Never go the results

D15. How satisfied were you with.....	Very Dissatisfied	Dissatisfied	Neither Satisfied nor Dissatisfied	Satisfied	Very Satisfied
a. Colon cancer information given by your provider's office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. The provider's explanation of the procedures to do the FOBT test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. The instructions on how to do the FOBT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Getting help from your clinic if you had questions about completing the FOBT kit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D18. How satisfied were you with (Please check the best answer)	Very Dissatisfied	Dissatisfied	Neither Satisfied nor Dissatisfied	Satisfied	Very Satisfied
---	-------------------	--------------	------------------------------------	-----------	----------------

- a. Dietary restrictions
- b. Overall preparations for the FOBT
- c. Completing the FOBT kit at home
- d. Collection of the stool sample
- e. Sending the sample to the clinic or lab
- f. The clinic or lab contacting you about your FOBT test results
- g. Explanation of the FOBT test results

D19. What motivated you to get screened with the FOBT? Please check (✓) all that apply.

	Yes	No
a. Talking with your provider.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Nurse or medical assistant.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Reading about colon cancer screening.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Friends or family members.....	<input type="checkbox"/>	<input type="checkbox"/>
e. Colon cancer screening materials received in the mail.....	<input type="checkbox"/>	<input type="checkbox"/>
f. Hearing about colon cancer screening in the media.....	<input type="checkbox"/>	<input type="checkbox"/>
g. Work wellness program.....	<input type="checkbox"/>	<input type="checkbox"/>
h. Other (Specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>

**Flexible Sigmoidoscopy (Flex Sig) (Please see the description on page X.)**

- D20. At your last primary care visit, did your provider talk with you about Flex Sig screening?  Yes (Continue)  
 No (If No, please go to Question D22)
- D21. At your last primary care visit, did your provider recommend Flex Sig screening?  Yes (If Yes, please go to Question D23)  
 No (Continue)
- D22. In the past 5 years did your doctor recommend a Flex Sig screening?  
 Yes (Continue)  
 No (IF NO, GO TO QUESTION D25)
- D23. Did you schedule a Flex Sig appointment?  
 Yes (Continue)  
 No (IF NO, GO TO QUESTION D25)\_\_\_
- D24.. Did you have the screening?  
 Yes  
 No

**Colonoscopy (Please see the description on page 5)**

- D25. At your last primary care visit, did your provider talk with you about Colonoscopy screening?  Yes (Continue)  
 No (If No, please go to Question D27)
- D26. At your last primary care visit, did your provider recommend Colonoscopy screening?  Yes (If Yes, please go to Question D28)  
 No (Continue)
- D27. In the past 10 years did your provider recommend a Colonoscopy screening?  
 Yes (Continue)  
 No (IF NO, PLEASE GO TO SECTION E)\_\_\_



D29. Did you or someone at the clinic schedule a Colonoscopy appointment for you?

- Yes (Continue)
- No (IF NO, PLEASE GO TO SECTION E)\_

D30. Did you receive a call or mail to remind you to keep your Colonoscopy appointment?  Yes  
 No

D31 Did you have the screening?

- Yes (Continue)
- No, I am still scheduled (If No, please go to Section E)
- No, I decided not to have it (If No, please go to Section E)

D32. How did you get the results?

- Phone call from the provider's office
- Letter from the provider's office
- In person
- Never got the results

D28. When your provider recommended the Colonoscopy, how satisfied were you with.....

	Very Dissatisfied	Dissatisfied	Neither Satisfied nor Dissatisfied	Satisfied	Very Satisfied
a. Colon cancer information given by your provider's office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Your provider's explanation of the Colonoscopy screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D33. When you had the Colonoscopy, how satisfied were you with:

	Very Dissatisfied	Dissatisfied	Neither Satisfied nor Dissatisfied	Satisfied	Very Satisfied
a. The process of making the Colonoscopy appointment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. The time interval between making the appointment and the actual screening appointment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Dietary restrictions for the Colonoscopy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



- d. Getting help from your clinic if you had questions about colonoscopy
- e. The use of laxative or enema.....
- f. Overall preparations for the Colonoscopy.....
- g. The convenience of the screening location.....
- h. How the screening specialist treated you.....
- i. Your comfort during the Colonoscopy procedure.....
- j. The doctor or clinic contacting you about your Colonoscopy test results.....
- k. Explanation of the Colonoscopy test results.....

D34. What motivated you to get screened by Colonoscopy? Please check (✓) all that apply.

	Yes	No
a. Talking with your provider.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Nurse or medical assistant.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Reading about colon cancer screening.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Friends or family members.....	<input type="checkbox"/>	<input type="checkbox"/>
e. Colon cancer screening materials received in the mail.....	<input type="checkbox"/>	<input type="checkbox"/>
f. Hearing about colon cancer screening in the media.....	<input type="checkbox"/>	<input type="checkbox"/>
g. Work wellness program.....	<input type="checkbox"/>	<input type="checkbox"/>
h. Other (Specify: _____).....	<input type="checkbox"/>	<input type="checkbox"/>

**Part V SECTION E: Your Opinions About Colon Cancer Knowledge**

E1. 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 fiber, like fruits, vegetables, and grains, may reduce your chances of getting colon cancer.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. <del>You should have your stool tested for hidden blood every year if you are 50 years or older.</del> <i>If you have colon cancer, you would have symptoms.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Part VI SECTION F: Your Opinions About Colon Cancer Screening**

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

F1. Discussing colon cancer screening with my ~~doctor~~ provider:

	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. <del>is something the doctor won't talk about because my insurance doesn't cover it.</del>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



- i. is hard to do because my doctor is not easy to talk to.
- j. is a waste of time because when I ask questions, the doctor doesn't have answers.
- k. 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 ABOUT FOBT (STOOL CARDS).

F2. Having an **FOBT** (Fecal Occult Blood Test):

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly 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 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 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 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 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 other diseases and cancers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. <i>is something I am sure I can do</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. is not necessary at my age.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. would be awful (disgusting) because I have to handle my stool.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. is a test I like being able to do in the privacy of my own home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. 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"/>
n. 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"/>
o. is something I don't know how to do correctly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. is a waste of time because the test is not	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

accurate.

- |   |                          |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| q. 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"/> |
| r. <i>would make me worry about the results</i>                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| s. <i>is unnecessary if I have a Flex Sig or a Colonoscopy</i>            | <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 Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly 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 ABOUT COLONOSCOPY.

F3. Having a Colonoscopy *screening* test:

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly 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. <i>is something I am sure I can do</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. 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"/>
k. 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"/>
l. 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"/>
m. is not necessary at my age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. would be embarrassing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. would be scary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. would be uncomfortable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. is not needed if I have had it once before	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. 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"/>
s. 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"/>
t. <i>would make me worry about the results</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u. <i>is hard because I would have to go to another clinic for the test</i>	<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 SCREENING, YOUR OPINIONS ARE IMPORTANT TO US.

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

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
<del>a. Fitting a flex sig screening test into my schedule is hard</del>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<del>b. I have trouble taking time off from work to do the flex sig test</del>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. 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"/>
b. I have trouble taking time off from work or changing my schedule to do the colonoscopy test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. 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"/>
<del>f. Medicare pays for flex sig screening</del>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<del>g. Medicare pays for colonoscopy screening</del>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<del>h. My insurance or health plan pays for flex sig screening</del>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<del>i. My insurance or health plan pays for colonoscopy screening</del>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I would do the FOBT kit if my doctor provider tells me to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I would do the flex sig screening if my doctor provider tells me to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I would do the colonoscopy screening if my doctor tells me to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. My doctor never provider always talks about screening for colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. My doctor never provider always 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"/>
i. My doctor never talks always talks about colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Part VII SECTION G: Social Support**

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

**G1. 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 checked="" type="checkbox"/> NA	<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 <del>doctor</del> provider 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"/>

**G2. 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 checked="" type="checkbox"/> NA	<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 <del>doctor</del> provider 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"/>

**G3. My having a screening colonoscopy screening is something that is encouraged by:**

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
a. my spouse or partner <input checked="" type="checkbox"/> NA	<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 <del>doctor</del> provider or nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

e. the popular media (TV, radio, magazines)





**Part VIII SECTION H: Plans to Talk About Colon Cancer or Get Screened**

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

**H1. Please answer the following questions about cancer screening:**

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
a. I plan to discuss colon cancer screening with my <del>doctor</del> <i>provider</i> at my next <del>check-up</del> <i>primary care visit</i> .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. <i>I plan to get screened for colon cancer in the next year.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I plan to do an FOBT <del>after my next check-up</del> <i>for colon cancer screening in the next year.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I plan to have a Flexible Sigmoidoscopy <del>after my next check-up</del> <i>for colon cancer screening in the next year.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I plan have a Colonoscopy <del>after my next check-up</del> <i>for colon cancer screening in the next year.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. <i>I plan to do whatever my doctor tells me to do for colon cancer screening in the next year.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Part IX: Colon Cancer Screening at Last Check-Up**

1. Please check (✓) if you or your doctor did the following things at your last check-up.

	Yes	No
a. <del>Did you receive any information about colorectal cancer screening in the mail, before your appointment?</del>	<input type="checkbox"/>	<input type="checkbox"/>
b. <del><b>IF YES:</b> Did you read through the information about colorectal cancer screening before your appointment?</del>	<input type="checkbox"/>	<input type="checkbox"/>
c. <del>Did you bring up colorectal cancer screening with your doctor?</del>	<input type="checkbox"/>	<input type="checkbox"/>
d. <del>Did your doctor bring up colorectal cancer screening with you?</del>	<input type="checkbox"/>	<input type="checkbox"/>
e. <del>Did any clinic staff (medical assistant, nurse) discuss colorectal cancer screening with you?</del>	<input type="checkbox"/>	<input type="checkbox"/>

**~~IF YOUR DOCTOR DID NOT TALK TO YOU ABOUT COLON CANCER SCREENING AT YOUR LAST CHECK-UP, PLEASE SKIP TO THE END.~~**

2. Please check (✓) how strongly you agree or disagree with the statements about your colorectal cancer screening discussion at **your last check-up**:

**Check-up and colorectal cancer screening experience:**

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
a. The doctor or other clinic staff made me feel that colorectal cancer screening was important for me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. The doctor or other clinic staff listened carefully to what I had to say.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. The doctor or other clinic staff answered all my questions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. The doctor or other clinic staff made me feel that screening could prevent colorectal cancer.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I trust that the doctor and other clinic staff have my best interest at heart.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. The doctor and other clinic staff act like I'm wasting their time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. The doctor and other clinic staff treat me in a very friendly and courteous manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Please check (✓) if you or your doctor did the following things at **your last check-up**:

	Yes	No
a. Did your doctor discuss colorectal cancer screening with an FOBT kit with you?	<input type="checkbox"/>	<input type="checkbox"/>
b. Did your doctor recommend that you should do your colorectal cancer screening with an FOBT kit?	<input type="checkbox"/>	<input type="checkbox"/>
c. Did you agree that you should do your colorectal cancer screening with an FOBT kit?	<input type="checkbox"/>	<input type="checkbox"/>
d. Did you get an FOBT home kit from your doctor or other clinic staff?	<input type="checkbox"/>	<input type="checkbox"/>
e. Did you phone the consulting nurse to ask questions about the FOBT home kit <b>after</b> your appointment?	<input type="checkbox"/>	<input type="checkbox"/>
f. Did you receive a phone call from a nurse or medical assistant <b>after</b> your appointment to ask about your FOBT home kit?	<input type="checkbox"/>	<input type="checkbox"/>
g. Did you return your FOBT cards to your doctor's office?	<input type="checkbox"/>	<input type="checkbox"/>

**IF YOU DID NOT GET AN FOBT HOME KIT DURING YOUR LAST CHECK-UP, PLEASE SKIP TO QUESTION 6.**

4. Please check (✓) how satisfied you were with your FOBT colon cancer screening experience from **your last check-up**:

**FOBT experience:**

	Very Dissatisfied	Somewhat Dissatisfied	Neither	Somewhat Satisfied	Very Satisfied
a. The way the doctor explained the need for the FOBT test.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. The way the doctor or clinic staff explained how to do the FOBT test.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. The interaction you had with the doctor during your visit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. The interaction you had with other clinic staff during your visit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Your check-up in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. The process of completing the FOBT kit at home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. How easy it was to return the completed kit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. The written instructions on how to complete your FOBT kit at home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. The help you received from the consulting nurse if you called her.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. The help you received from the nurse or medical assistant if s/he called you.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Please check (✓) how strongly you agree or disagree with the statements describing your colorectal cancer screening experience with the FOBT kit you got at **your last check-up**:

**FOBT experience:**

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
a. The diet restrictions of the FOBT were easy to follow.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Completing the FOBT kit at home was easy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. The directions for completing the FOBT kit were easy to understand.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I knew who I could call if I had questions about completing the FOBT kit at home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Waiting for the test results made me worry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Please check (✓) if you or your doctor did the following things at **your last check-up**:

	Yes	No
a. Did your doctor discuss a screening flex sig with you?	<input type="checkbox"/>	<input type="checkbox"/>
b. Did any clinic staff (medical assistant, nurse) discuss a screening flex sig with you	<input type="checkbox"/>	<input type="checkbox"/>
c. Did your doctor recommend that you should do your colorectal cancer screening with a flex sig?	<input type="checkbox"/>	<input type="checkbox"/>

- d. ~~Did you agree that you should do your colorectal cancer screening with a flex sig?~~
- e. ~~Did you schedule for a flex sig appointment?~~
- IF YES:**
- f. ~~Did you receive a phone call or post card to remind you to keep your appointment for the flex sig?~~
- g. ~~Did you keep your flex sig appointment?~~
- h. ~~Are you still waiting for your flex sig appointment?~~

**IF YOU DID NOT DISCUSS FLEX SIG FOR COLON SCREENING DURING YOUR LAST CHECK-UP, PLEASE SKIP TO QUESTION 9.**

7. Please check (✓) how satisfied you were with discussing flex sig during your last check-up:

<b>FLEX SIG DISCUSSION:</b>	<b>Very Dissatisfied</b>	<b>Somewhat Dissatisfied</b>	<b>Neither</b>	<b>Somewhat Satisfied</b>	<b>Very Satisfied</b>
a. The way the doctor explained the need for the flex sig test.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. The way the doctor explained how the flex sig was done.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. The interaction you had with the doctor about flex sig.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. The interaction you had with other staff about flex sig.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. The process of making the appointment for the flex sig.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. The written instructions on how to prepare for the appointment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. The way the doctor explained the dietary restrictions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**IF YOU HAVE NOT YET HAD YOUR FLEX SIG SCREENING APPOINTMENT, PLEASE SKIP TO QUESTION 9.**

8. Please check (✓) how strongly you agree or disagree with the statements describing your flex sig experience:

<b>Flex Sig experience:</b>	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Neither Agree nor Disagree</b>	<b>Agree</b>	<b>Strongly Agree</b>
a. The dietary restrictions to prepare for the flex sig were easy to follow.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. It was hard to wait for the appointment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. The staff at the flex sig appointment were helpful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Waiting for the test results made me worry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I knew who I could call if I had questions about the flex sig appointment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Keeping the appointment was easy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Please check (✓) if you or your doctor did the following things at **your last check-up**.

	Yes	No
a. Did your doctor discuss a screening colonoscopy with you?	<input type="checkbox"/>	<input type="checkbox"/>
b. Did any clinic staff (medical assistant, nurse) discuss a screening colonoscopy with you?	<input type="checkbox"/>	<input type="checkbox"/>
c. Did your doctor recommend that you should do your colorectal cancer screening with a colonoscopy?	<input type="checkbox"/>	<input type="checkbox"/>
d. Did you agree that you should do your colorectal cancer screening with a colonoscopy?	<input type="checkbox"/>	<input type="checkbox"/>
e. Did you schedule for a colonoscopy appointment?	<input type="checkbox"/>	<input type="checkbox"/>
<b>IF YES:—</b>		
f. Did you receive a phone call or post card to remind you to keep your appointment for the colonoscopy?	<input type="checkbox"/>	<input type="checkbox"/>
g. Did you keep your colonoscopy appointment?	<input type="checkbox"/>	<input type="checkbox"/>
h. Are you still waiting for your colonoscopy appointment?	<input type="checkbox"/>	<input type="checkbox"/>

**IF YOU DID NOT DISCUSS COLONOSCOPY FOR COLON SCREENING DURING YOUR LAST CHECK-UP, PLEASE SKIP TO THE END.**

10. Please check (✓) how satisfied you were with your colonoscopy screening experience.

	Very Dissatisfied	Somewhat Dissatisfied	Neither	Somewhat Satisfied	Very Satisfied
a. The way the doctor explained the need for the colonoscopy test.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. The way the doctor explained how the colonoscopy was done.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. The interaction you had with the doctor about colonoscopy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. The interaction you had with other staff about colonoscopy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. The process of making the appointment for the colonoscopy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. The written instructions on how to prepare for the appointment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. The way the doctor explained the dietary restrictions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Please check (✓) how strongly you agree or disagree with the statements describing your colonoscopy experience.

~~IF YOU HAVE NOT YET HAD YOUR COLONOSCOPY SCREENING APPOINTMENT, PLEASE SKIP TO THE END.~~

<del>Colonoscopy experience:</del>	<del>Strongly Disagree</del>	<del>Disagree</del>	<del>Neither Agree nor Disagree</del>	<del>Agree</del>	<del>Strongly Agree</del>
<del>a. The dietary restrictions to prepare for the colonoscopy were easy to follow.</del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>
<del>b. It was hard to wait for the appointment.</del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>
<del>c. The staff at the colonoscopy appointment were helpful.</del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>
<del>d. Waiting for the test results made me worry.</del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>
<del>e. I knew who I could call if I had questions about the colonoscopy appointment.</del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>
<del>f. Keeping the appointment was easy.</del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>

*Please let us know if you have any additional comments:*

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**THE END**

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

Please place it in the enclosed, stamped, envelope [,along with your signed HIPPA authorization form ABQ AP/Lovelace onl] and drop it in the mail for us!