

Location of Event \_\_\_\_\_ Date of Event \_\_\_\_\_

Please list your initials \_\_\_\_\_ and your date of birth (month, day & year): \_\_\_\_ / \_\_\_\_ / \_\_\_\_.

Are you Hispanic or Latino? <sup>1</sup> Yes <sup>2</sup> No

What term best describes your race?

- <sup>1</sup> White/Caucasian      <sup>2</sup> Black/African American      <sup>3</sup> Asian      <sup>4</sup> American Indian/Alaskan Native  
<sup>5</sup> Native Hawaiian/Pacific Islander      <sup>6</sup> Mixed race      <sup>7</sup> Other \_\_\_\_\_

**By answering this Pre-Tour survey, you are agreeing to participate in a study that will help us understand how well this Inflatable Colon Exhibit is at teaching people about colon cancer. Completing this survey is optional and NOT required for entrance into the inflatable colon. You can also skip any questions you are not comfortable answering.**

**PLEASE ANSWER THE FOLLOWING QUESTIONS BEFORE WALKING THROUGH THE INFLATABLE COLON**

**QUESTIONS**

		YES	NO
1.	Have you ever walked through an inflatable colon before?	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>
2.	Do you know what a colon polyp is?	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>
3.	Do you know what colon cancer is?	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>
4.	Have you ever talked to your doctor about colon cancer?	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>
5.	Do you know what a cancer screening test is?	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>
6.	Do you know what the different types of screening tests available for colon cancer are?	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>
7.	Has your doctor ever recommended you have a fecal occult blood test (FOBT), sigmoidoscopy, or colonoscopy?	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>
8.	Do you think most patients survive colon cancer if it is found early and removed?	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>

9. How much do you feel you know about colon cancer now?  
<sup>1</sup> Unknowledgeable      <sup>2</sup> Somewhat Knowledgeable      <sup>3</sup> Very Knowledgeable

10. How much do you feel you know about how colon cancer progresses now?  
<sup>1</sup> Unknowledgeable      <sup>2</sup> Somewhat Knowledgeable      <sup>3</sup> Very Knowledgeable

		NOT LIKELY	SOMEWHAT LIKELY	VERY LIKELY
11.	How likely are you to talk to your doctor about colon cancer screening?	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>
12.	How likely are you to get screened for colon cancer based on American Cancer Society's recommendations?	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>
13.	How likely are you to talk about colon cancer with:			
	a) Your relatives (parents, siblings, aunts, uncles, cousins, etc.)	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>
	b) Your peers (friends, colleagues, etc.)	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>
	c) Your community members	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>
	d) Other individuals at risk (those 50+ or those with a family history, etc.)	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>

14. What is your gender? <sup>1</sup> Male <sup>2</sup> Female

15. What year were you born in? 19 \_\_ \_\_ [IF YOU CAN'T REMEMBER YEAR: How old are you?]: \_\_\_\_\_

16. Do you have any of the following health care plans?

- <sup>1</sup> Private health insurance <sup>2</sup> Medicare  
<sup>3</sup> Medicaid <sup>4</sup> None  
<sup>5</sup> Other → Specify: \_\_\_\_\_

17. Have you ever had one of the following colon cancer screening tests?

a) Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT)

- <sup>1</sup> Yes → [IF YES, what year? \_\_\_\_\_]  
<sup>2</sup> No

b) Sigmoidoscopy

- <sup>1</sup> Yes → [IF YES, what year? \_\_\_\_\_]  
<sup>2</sup> No

c) Colonoscopy

- <sup>1</sup> Yes → [IF YES, what year: \_\_\_\_\_]  
<sup>2</sup> No

Thanks for completing this survey!