Supplementary Questionnaire 2.

Virtual Reality Headset PATIENT Pre-procedure Questionnaire

Please complete this short questionnaire about yourself.

1. Today's date: ___ /___ /___

2. Age: _____ What is your month & year of birth? ___ /___

3. Which of these options best describes your ethnicity?
   - ☐ White Caucasian
   - ☐ Asian
   - ☐ Afro-Caribbean or African
   - ☐ Other (*specify*): _____

4. Have you been through the menopause?
   - ☐ Yes
   - ☐ Currently going through it (menopausal symptoms but still having periods)
   - ☐ No

5. Have you had children?
   - ☐ Yes
   - ☐ No

6. Did you have a vaginal delivery?
   - ☐ Yes
   - ☐ No
   - ☐ Not applicable

7. Did you take any pain relief before the procedure?
   - ☐ Yes
   - ☐ No

8. Which medication(s) did you take? (*Please tick all that apply*)
   - ☐ None
   - ☐ Paracetamol
   - ☐ NSAIDs (e.g. Ibuprofen, naproxen, diclofenac, mefenamic acid, etc)
   - ☐ Codeine phosphate
   - ☐ Co-codamol
   - ☐ Other (*specify*): _____

9. Roughly how long before the procedure did you take the medication? _____ mins

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10. Please place a mark (**X**) on the scale indicating the amount of pain you **expect** during the procedure?

0	5	10
No pain at all	Moderate pain	Worst pain imaginable
		

11. Please place a mark (**X**) on the scale indicating your **current** level of anxiety regarding the procedure?

0	5	10
No anxiety at all	Moderate anxiety	Worst anxiety imaginable
		