Supplementary Questionnaire 4.

Virtual Reality Headset PATIENT Post-procedure Questionnaire

Please complete this short questionnaire about yourself and your experience of using of the Virtual Reality headset for pain control.

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

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

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

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





4. How would you describe your overall experience today?
   - ☐ 1 - Very acceptable
   - ☐ 2 - Acceptable
   - ☐ 3 - Neither acceptable nor unacceptable
   - ☐ 4 - Unacceptable
   - ☐ 5 - Very unacceptable

5. Would you recommend this procedure?
   - ☐ Yes
   - ☐ No

6. Did you use the Virtual Reality headset during the procedure?
   - ☐ Yes throughout
   - ☐ Yes, for part of it (*if you tick this box, please answer question 6a*)

6a. If you stopped using the Virtual Reality headset during the procedure, can you tell us why? (*Please tick all that apply*):
   - ☐ Headset uncomfortable
   - ☐ Anxiety
   - ☐ Wanted to see what was going on (i.e. not be distracted)
   - ☐ Claustrophobia
   - ☐ Other (*specify*): _____

Supplementary Questionnaire 4.

7. Which side effects did you experience from the Virtual Reality headset? (*Please tick all that apply*)

   - ☐ None
   - ☐ Nausea
   - ☐ Vomiting
   - ☐ Dizziness
   - ☐ Discomfort
   - ☐ Claustrophobia
   - ☐ Other (*specify*): _____

8. Please provide any comments about your experience?

   _____
   _____
   _____
   _____