Participant
Virtual Reality Screening Form

Please answer the following questions.

Question	Answer
Are you of 18 years of age or older?	Y / N
Do you have a heart condition?	Y / N
If so, please describe:	
Do you have an implanted medical device? (i.e. pacemaker, cochlear implant…)	Y / N
If so, please describe:	
Have you ever had a seizure?	Y / N
If so, please describe:	
Do you have a family history of seizures or epilepsy?	Y / N
If so, please describe:	
Are you currently pregnant?	Y / N
Are you prone to motion sickness or dizziness?	Y / N
Have you ever had an adverse reaction to virtual reality?	Y / N

____________________________ NAME

____________________________ SIGNITURE