Example

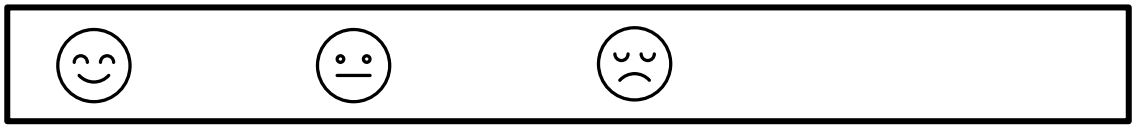
DREAMS ID/NAME:

Age:

Organization:

Thank you for taking the time to fill in this questionnaire. Your opinion are really important to us. **Please, fill all the questions inside each down box.**

How do you feel about your menstruation?



Have you used the Cup? If yes, for how many months?

Do you think that using the Cup is:

- ☐ easy
- ☐ tricky at first, then you get used to it
- ☐ difficult

What is your favorite product to manage your menstruation? You can choose more than one.

- ☐ Product 1
- ☐ Product 2
- ☐ Others

Would you recommend the Cup to your friends?