

**DATA SHEET**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Experimenter: \_\_\_\_\_ Evaluator: \_\_\_\_\_

SESSION ONE                       SESSION TWO

**Met Requirement?**

At what time did you last eat? \_\_\_\_\_ Yes  No   
(nothing within 2 hrs.)

What time did you last consume liquids? \_\_\_\_\_ Yes  No   
(nothing within 2 hrs.)

What time did you last consume caffeine? \_\_\_\_\_ Yes  No   
(nothing within 2 hrs.)

When did you last smoke? \_\_\_\_\_ Yes  No   
(none within 1 hrs.)

When did you last consume alcoholic beverages? \_\_\_\_\_ Yes  No   
(none within 48 hrs)

Did you do any exercise today or yesterday? \_\_\_\_\_ Yes  No   
(none within 24 hrs)

Have you taken antibiotics, OTCs, or herbal supplements within the past month? \_\_\_\_\_ Yes  No   
(none 24 hrs – prompt about vitamin intake if not mentioned by participant)  
(If yes, details) \_\_\_\_\_

Have you had a cold/flu or other infection within the past 2 weeks? \_\_\_\_\_ Yes  No   
(no cold/flu symptoms within 2 weeks)  
(If yes, details) \_\_\_\_\_

Do you have any of the following symptoms?

Runny nose	yes/ no	Sore throat	yes/ no
Nasal congestion	yes/ no	Headache	yes/ no
Cough	yes/ no	Tiredness	yes/ no

Waiting room saliva sample Time: \_\_\_\_\_

**INVESTIGATOR’S COMMENTS:**