Reaction Time Experiment Participant Questionnaire

1. Name: ……………………………………………..
2. Age: ………..
3. Gender?  
    Male [ ]

Female [ ]

1. Have you had any caffeine in the past 12 hours? E.g Coffee, Tea, Fizzy Drinks, Cocoa, caffeine tablets, medication including caffeine.  
    Yes [ ]  
    No [ ]
2. Do you have any eye disorders/problems that will affect reaction time?

Yes [ ]  
 No [ ]

1. Can you read a number plate from 20m away?

Yes [ ]  
 No [ ]

1. Do you smoke more than 1 cigarette a day?

Yes [ ]  
 No [ ]

1. Have you been awake for longer than an hour?

Yes [ ]  
 No [ ]

1. Do you do exercise more than 4 hours a week?

Yes [ ]  
 No [ ]

1. Do you currently have a respiratory illness? E.g cough/cold

Yes [ ]  
 No [ ]