

Date Kit provided to participant:  _ _ / _ _ / _ 2_ 0_ _ _	Date Samples picked up  _ _ / _ _ / _ 2_ 0_ _ _
KIT ID	
Assignment ID:	Site ID:
Participant ID:	Visit type: <input type="checkbox"/> T1 Mom <input type="checkbox"/> T1 Prior <input type="checkbox"/> T1 Dad
Data Collector ID:	<input type="checkbox"/> T3 First <input type="checkbox"/> T3 Prior
	<input type="checkbox"/> 6 Month

## National Children’s Study DAY 1: ADULT SALIVA DATA COLLECTION FORM

**\*\*Please collect your saliva sample on the 2 days following our visit to your home on \_\_\_\_\_. Please write down the exact time that you collected each saliva sample in the spaces below.**

### Day 1 Saliva Samples

**What is the date you collected the Day 1 saliva samples? \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year**

Tube #	When to take sample	Time collected	For Office Use Only
Wake	As soon as you wake up	____:____ a. ____ am b. ____ pm <b>(Answer questions 1 &amp; 2)</b>	Sample collected <input type="checkbox"/> Yes <input type="checkbox"/> No

**Please answer the following question after you have collected the Wake saliva sample:**

**1. Did you spend any time dozing in bed within 2 hours before the time that you woke up and collected the first saliva sample (Wake saliva sample) this morning?**

Yes  No

**2. If yes, estimate of time spent dozing before collecting the Wake saliva sample.**

\_\_\_\_\_ minutes

Tube #	When to take sample	Time collected	For Office Use Only
+30	30 minutes after waking up	____:____ a. ____ am b. ____ pm (check am or pm)	Sample collected <input type="checkbox"/> Yes <input type="checkbox"/> No

Tube #	When to take sample	Time collected	For Office Use Only
<b>Bedtime</b>	<b>Before brushing your teeth and at least 1 hour after eating for the last time today</b>	____:____ a. __ am b. __ pm  <b>(Answer questions 3, 4 &amp; 5)</b>	Sample collected <input type="checkbox"/> Yes <input type="checkbox"/> No

**Please answer the following questions after you have collected the Bedtime saliva sample:**

**3. During the past 2 hours have you done any of the following:**

- a. Consumed a caffeinated beverage (coffee, tea, soda)?  Yes  
 No
- b. Smoked?  Yes  No
- c. Consumed alcohol?  Yes  No

**4. During the past 2 hours has your physical activity been (circle the correct answer):**

- Light? (standing, walking light, light house work)
- Moderate? (yard work, brisk walking)
- Intense? (jogging, exercise classes)

**5. Please write down the name of any prescription or over the counter medications that you have taken today. Please be specific. For example, if you took Robitussin DM<sup>®</sup>, write Robitussin DM<sup>®</sup> not Robitussin<sup>®</sup>.**

_____	_____
_____	_____
_____	_____

**Please feel free to call if you have any questions:**  
 [X at phone #]