

Please answer the following questions:

	Not at all	No more than usual	Rather more	Much more	Care not to answer	
<b>1</b> After the task, how stressed do you feel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>2</b> After the task, how exhausted do you feel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	None at all	Very little	Some	Great	Care not to answer	
<b>3</b> How much effort did you exert solving the mathematical problems in the previous 10 minutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Not at all	Neutral	Somewhat	Great	Care not to answer	
<b>4</b> Did you feel under strain when solving the mathematical problems in the previous 10 minutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	Other	
<b>5</b> What year of studies are you in?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	18-20	21-23	24-26	27-29	30 or older	
<b>6</b> How old are you in years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Female			Male		
<b>7</b> Which do you identify most with?	<input type="checkbox"/>			<input type="checkbox"/>		
	Business school		Arts and Social Sciences	Physical Sciences	Life Sciences	
<b>8</b> In what area is your intended degree? (If you have a joint degree, indicate college that you prefer)	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					Yes	No
Tick any of the following that may apply. In the two hours immediately before this experiment did you... (Please tick all that apply)						
<b>9</b> ... Have food					<input type="checkbox"/>	<input type="checkbox"/>
<b>10</b> ... Use caffeine products (e.g. coffee)					<input type="checkbox"/>	<input type="checkbox"/>
<b>11</b> ... Use nicotine products (e.g. cigarettes)					<input type="checkbox"/>	<input type="checkbox"/>
<b>12</b> ... Drink alcohol					<input type="checkbox"/>	<input type="checkbox"/>

**Please turn the page to continue the survey.**

	Yes	No
<b>13</b> ... Participate in moderate vigorous exercise	<input type="checkbox"/>	<input type="checkbox"/>
<b>14</b> ... Wake up from a night's sleep	<input type="checkbox"/>	<input type="checkbox"/>
<b>15</b> ... Brush your teeth	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
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Your cortisol levels can be influenced by different medications in different ways. To allow us to control for the potential effect of any medication, please indicate if you have taken any of the following medication types from each of the groups within the last 24 hours. Please note that a medication type may occur in more than one group so please read the list carefully and indicate 'yes' for each group that the medication type occurs in.

<b>16</b>	Selective serotonin reuptake inhibitor (SSRI), tricyclic anti-depressants, antipsychotics, benzodiazepines or narcotic/non-narcotic pain reliever.	<input type="checkbox"/>	<input type="checkbox"/>
<b>17</b>	Selective serotonin reuptake inhibitor (SSRI), synthetic steroids, antifungal, opiate agonist, uterine-active agent, diuretic antidiuretic, sympathomimetic agents (e.g. decongestant), phenothiazines or monoamine oxidase inhibitor.	<input type="checkbox"/>	<input type="checkbox"/>
<b>18</b>	Corticosteroids (anti-inflammatory oral, nasal, topical or ophthalmic treatment).	<input type="checkbox"/>	<input type="checkbox"/>
<b>19</b>	Hypolipemic, statins, resins, synthetic steroid or progestin only pills (e.g. progestin-only contraceptive).	<input type="checkbox"/>	<input type="checkbox"/>
<b>20</b>	Alpha adrenergic receptor antagonist, alpha adrenergic receptor agonist (e.g. treatment of ADHD), beta adrenergic receptor antagonist or beta adrenergic receptor agonist (e.g. treatment of asthma).	<input type="checkbox"/>	<input type="checkbox"/>
<b>21</b>	Anti-cholinergic (e.g. treatment of asthma or IBS) or cholinergic.	<input type="checkbox"/>	<input type="checkbox"/>
<b>22</b>	Estrogen replacement therapy or contraceptives.	<input type="checkbox"/>	<input type="checkbox"/>

Please put the questionnaire back into the envelope when you are finished. Thank you.