



BEGIN WITH THE BASICS



GUTS 2003

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0	0	0	3
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	5	5	
	6	6	5
	7	7	
	8	8	6
	9	9	

1. Is this your correct Date of Birth? Yes No → If No, please write your date of birth:

MONTH / DAY / YEAR

2. How tall are you? _____ feet _____ inches

This is your ID

G03

3. How much do you weigh? _____ pounds

4. What is your marital status?
 Never married Married Other

5. Where do you live most of the time?
 In apartment or house In a sorority house In a dorm Military Other

6. Who do you live with most of the time? (Mark all that apply.)
 Parent(s) Partner or spouse Roommate(s) I live alone Other

TIME IN THE SUN

1. How many times did you get a sunburn this past summer (that is, how many times did exposed parts of your skin stay red for several hours after you had been out in the sun)?

- Didn't get a sunburn
- 1 time
- 2 times
- 3-4 times
- 5 or more times

2. During the past year, how many times did you use a tanning booth or tanning salon?

- Never
- 1 time
- 2 times
- 3-4 times
- 5-9 times
- 10 or more times

3. When you went outside on a sunny day this past summer for more than 15 minutes, how often did you ...

	NEVER	SELDOM	SOMETIMES	OFTEN	ALWAYS
Use sunscreen or sunblock with an SPF of 15 or more?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wear a shirt with sleeves?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wear a hat?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Limit time spent in the sun between 10am and 4pm?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lie in the sun to get a suntan?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

MOVIE/TV/MAGAZINE SCENE

1. Do you read or look through any magazines regularly? Yes No

Please tell us the names of the 2 magazines you read most frequently.

1. _____ 2. _____

2. On average, how many hours per week do you spend watching TV? (a total for the entire 7 day week)

- None
- 1-5 hours
- 6-10 hours
- 11-15 hours
- 16-20 hours
- 21-30 hours
- 31+ hours

3. In the past year, how much have you tried to look like the girls or women you see on television, in movies, or in magazines?

- Totally
- A lot
- Pretty much
- Sometimes
- A little
- Not at all

To look like them I have changed or I'm trying to change my ... (Mark all that apply.)

- Hair color
- Hair style
- Makeup
- Clothing
- Body shape
- Muscle definition
- Tan/skin color
- Weight (trying to gain)
- Weight (trying to lose)
- Other

A	1	1	1	1	1	1	1	1	a
B	2	2	2	2	2	2	2	2	b
C	4	4	4	4	4	4	4	4	
D	8	8	8	8	8	8	8	8	
E	P	P	P	P	P	P	P	P	

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HOW YOU FEEL *Mark one answer for each statement.*

1. In the past year, how often did you:

	ALWAYS	USUALLY	SOMETIMES	RARELY	NEVER
Feel worthless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Notice you didn't have as much energy as you usually do?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feel "down in the dumps" or "depressed"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feel hopeful about the future?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have trouble concentrating?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have trouble enjoying activities you usually enjoy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. How much do these statements describe you?

	REALLY TRUE FOR ME	SORT OF TRUE FOR ME	NOT TRUE FOR ME
<i>Some people are happy with themselves most of the time.</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Some people are often disappointed with themselves.</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Some people like the kind of person they are.</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Some people don't like the way they are leading their life.</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Some people are very happy being the way they are.</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

QUESTIONS ABOUT WEIGHT

There are no right or wrong answers. We just want to know what you think.

1. How would you describe your weight?

Very underweight
 Slightly underweight
 About the right weight
 Slightly overweight
 Very overweight

2. Which of the following are you trying to do about your weight?

I am *not trying to do anything* about my weight. Go to question 3.
 Stay the same
 Gain weight
 Lose weight

During the past year, how often did you go on a diet to lose weight or keep from gaining weight?

Never
 A couple of times
 Several times
 Often
 Always on a diet

How long did you stay on the diet(s)?

Less than a week
 1-3 weeks
 1-3 months
 3 or more months

During the past year, how often did you exercise to lose weight or keep from gaining weight?

Never
 Less than monthly
 1-3 times a month
 1-4 times per week
 5 or more times per week

Did you exercise to lose weight or keep from gaining weight even when you were sick or injured?

No
 Yes, sometimes
 Yes, frequently

Was it difficult for you to do your work or school work because of the amount of time that you were exercising to lose weight or keep from gaining weight?

No
 Yes, sometimes
 Yes, frequently

During the past year, did you do any of the following to lose weight or keep from gaining weight?

	NEVER	LESS THAN MONTHLY	1-3 TIMES A MONTH	ONCE PER WEEK	2-6 TIMES PER WEEK	DAILY
Fast (not eat for at least a day)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Make yourself throw up	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Take laxatives	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. Has anyone ever told you that they thought you had an eating disorder, such as anorexia nervosa or bulimia nervosa? (Mark all that apply.)

No
 Yes, a friend
 Yes, a parent
 Yes, a doctor, nurse, or other health care provider

4. Have you ever been treated for an eating disorder by a doctor, nurse, or other health care provider?

No
 Yes, in the past
 Yes, currently

5. Sometimes people will go on an "eating binge", where they eat an amount of food that most people, like their friends, would consider to be very large, in a short period of time. During the past year, how often did you go on an eating binge?

- Never Go to next page.
- Less than once a month
- 1-3 times a month
- Once a week
- More than once a week

Was there a period of at least 3 months during the past year when you went on eating binges frequently?

- No
- Yes, weekly
- Yes, more than weekly

THESE QUESTIONS REFER TO WHEN YOU WERE ON A BINGE.

	NO	YES
Did you feel out of control, like you couldn't stop eating even if you wanted to stop?	<input type="radio"/>	<input type="radio"/>
Did you eat very fast or faster than you normally do?	<input type="radio"/>	<input type="radio"/>
Did you eat until your stomach hurt or you felt sick to your stomach?	<input type="radio"/>	<input type="radio"/>
Did you eat really large amounts of food when you didn't feel hungry?	<input type="radio"/>	<input type="radio"/>
Did you eat by yourself because you did not want anyone to see how much you ate?	<input type="radio"/>	<input type="radio"/>
Did you feel really bad about yourself or feel guilty after eating a lot of food?	<input type="radio"/>	<input type="radio"/>

6. Describe what you ate in your last eating binge.

	AMOUNT		
SWEETS			
ice cream	<input type="radio"/> 1-2 scoops	<input type="radio"/> 3-4 scoops	<input type="radio"/> 5 or more scoops
frozen yogurt	<input type="radio"/> 1-2 scoops	<input type="radio"/> 3-4 scoops	<input type="radio"/> 5 or more scoops
candy bars	<input type="radio"/> 1-2 candy bars	<input type="radio"/> 3-4 candy bars	<input type="radio"/> 5 or more candy bars
donuts	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3 or more
cookies	<input type="radio"/> 1-5	<input type="radio"/> 6-9	<input type="radio"/> 10 or more
cake	<input type="radio"/> 1 slice	<input type="radio"/> 2 slices	<input type="radio"/> 3 or more slices
poptarts	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3 or more
SALTY SNACKS			
potato or corn chips	<input type="radio"/> 1 small bag	<input type="radio"/> 2 small bags	<input type="radio"/> 1 or more large bags
popcorn	<input type="radio"/> 1 small bag	<input type="radio"/> 2 small bags	<input type="radio"/> 1 or more large bags
nuts	<input type="radio"/> 1-2 handfuls	<input type="radio"/> 3-4 handfuls	<input type="radio"/> 5 or more handfuls
BREAD OR CEREAL			
bread	<input type="radio"/> 1-2 slices	<input type="radio"/> 3-4 slices	<input type="radio"/> 5 or more slices
bagels or rolls	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3 or more
danish or sweet rolls	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3 or more
muffin	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3 or more
cold cereal	<input type="radio"/> 1 bowl	<input type="radio"/> 2 bowls	<input type="radio"/> 3 or more bowls
DAIRY			
yogurt	<input type="radio"/> 1 small container	<input type="radio"/> 2 small containers	<input type="radio"/> 3 or more small containers
cheese	<input type="radio"/> 1-2 slices	<input type="radio"/> 3-4 slices	<input type="radio"/> 5 or more slices
MAIN DISHES			
spaghetti or pasta	<input type="radio"/> 1 bowl	<input type="radio"/> 2 bowls	<input type="radio"/> 3 or more bowls
pizza	<input type="radio"/> 1-2 slices	<input type="radio"/> 3-4 slices	<input type="radio"/> 5 or more slices
chicken	<input type="radio"/> 1 breast	<input type="radio"/> 2 breasts	<input type="radio"/> 3 or more breasts
sandwich	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3 or more

OTHER Are there other foods that you ate during your last eating binge?

FOOD	AMOUNT
1. _____	_____
2. _____	_____

7. In the past year, if there was a period of time when you went on eating binges at least weekly, how long did it last?

- Doesn't apply to me
- 1 month
- 2 months
- 3 or more months

During that time did you do any of the following? (Mark all that apply.)

- Exercised a lot to burn off the calories I had eaten during the eating binges
- Used laxatives to keep from gaining weight
- Made myself throw up to keep from gaining weight
- Monthly
- Weekly
- Two or more times a week
- Monthly
- Weekly
- Two or more times a week

Go to Next Page

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8. In the past year, how often have . . .

**Remember
there
are
no
right
or
wrong
answers.**

**We
just
want
to
know
what
you
think.**

you thought about wanting to have toned or defined muscles?

- Never A Little Sometimes A Lot Always

your girl friends talked about wanting to lose weight?

- Never A Little Sometimes A Lot Always

you worried about having fat on your body?

- Never A Little Sometimes A Lot Always

you changed your eating when you were around *boys/men*?

- Never A Little Sometimes A Lot Always

you tried to change your weight so you would not be teased by *boys/men* (including brothers)?

- Never A Little Sometimes A Lot Always

you thought about wanting to be thinner?

- Never A Little Sometimes A Lot Always

***you* tried to lose weight?**

- Never A Little Sometimes A Lot Always

you changed your eating when you were around *girls/young women*?

- Never A Little Sometimes A Lot Always

***girls/women* (including sisters) made fun of you because of your weight?**

- Never A Little Sometimes A Lot Always

***boys/men* (including brothers) made fun of you because of your weight?**

- Never A Little Sometimes A Lot Always

you felt fat?

- Never A Little Sometimes A Lot Always

you tried to change your weight so you would not be teased by *girls/women* (including sisters)?

- Never A Little Sometimes A Lot Always

A	1	1	1	1	1	1	1
B	2	2	2	2	2	2	2
C	4	4	4	4	4	4	4
D	8	8	8	8	8	8	8
E	P	P	P	P	P	P	P

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9. In the past year, how important has it been to your friends that . . .

***they* be thin?**

- Not At All A Little Pretty Much A Lot Totally Not Sure

***you* be thin?**

- Not At All A Little Pretty Much A Lot Totally Not Sure

10. In the past year, how much . . .

do you think your weight made *boys/men* NOT like you?

- Not At All A Little Pretty Much A Lot Totally

has your weight made a difference in how you feel about yourself?

- Not At All A Little Pretty Much A Lot Totally

have you worried about gaining two pounds?

- Not At All A Little Pretty Much A Lot Totally

1. Has a doctor ever said you have asthma? Yes No Not Sure

SMOKING

1. In the coming year, do you think you will smoke a cigarette, even a few puffs?

- Definitely not Maybe Probably Definitely

2. In the PAST YEAR, have you smoked a cigarette, even a few puffs?

- No Go to question 3. Yes →

A	1	1	1	1	1	1	1	1	1	1
B	2	2	2	2	2	2	2	2	2	2
C	4	4	4	4	4	4	4	4	4	4
D	8	8	8	8	8	8	8	8	8	8
E	P	P	P	P	P	P	P	P	P	P

Have you smoked at least 100 cigarettes (5 packs) in your life? No Yes

How long ago did you smoke your last cigarette?

- In past week In past month, but not in past week 1-3 months 4-6 months 6+ months

When you are smoking, . . .

how many cigarettes do you smoke in one day?

- Don't smoke 1 2-5 6-10 11-20 21 or more

how often do you smoke?

- Don't smoke Less than once a month Less than once a week 1-2 days per week
 3-5 days per week Almost everyday Daily

do you smoke . . .

- Mainly with other people Mainly by yourself As often by yourself as with other people

is it difficult for you not to smoke in a place where smoking is forbidden?

- Very difficult Difficult Somewhat difficult Slightly difficult Not at all difficult

do you smoke more in the morning than the rest of the day?

- Always Usually Sometimes Rarely Never

do you smoke when you are really sick (i.e., coughing or vomiting a lot)?

- Always Usually Sometimes Rarely Never

how deeply do you inhale the smoke?

- Just into the mouth As far back as the throat Partly into the chest Deeply into the chest

how soon after waking in the morning do you smoke your first cigarette?

- When I first open my eyes Within the first 15 minutes Between 15 and 30 minutes
 Between 30 and 60 minutes Between 1 and 2 hours More than 2 hours

In the PAST YEAR, have you quit smoking? No Yes, and stayed quit Yes, but restarted

Do you intend to quit smoking in the next year? No Yes Already quit

Do you think you would be able to stop smoking if you wanted to? No Yes Maybe Already quit

3. How many of your friends smoke cigarettes? None One A few Most All

4. Which statement best describes the rules about smoking inside the place where you live most of the time?

- No one is allowed to smoke anywhere Smoking is allowed in some places or at some times Smoking is permitted anywhere

5. How do you think your mother would react if you were smoking cigarettes and she knew about it? She would. . .

- Tell me to stop and be very upset Tell me to stop but not be too upset Not tell me to stop, but would disapprove
 Have no reaction Don't know how she would react

6. In the past year, have you bought or been given stuff like a hat, T-shirt, or bag with the name of a cigarette on it (like Camel, Marlboro, or Virginia Slims)? No Yes

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7. Who in your family smokes cigarettes? (Mark all that apply.)

- Mother
- Father
- Sister(s)
- Brother(s)
- Spouse or partner

PERSONAL RELATIONSHIPS

1. Have you ever had sexual intercourse?

- No Go to question 3.
- Yes
- Not sure

During your life, with how many people have you had sexual intercourse?

- 1 person
- 2 people
- 3 people
- 4 people
- 5 people
- 6 or more people

2. In the past year, have you had sexual intercourse?

- No Go to question 3.
- Yes
- Not sure

Have you had sexual intercourse for the first time in the past year?

- No
- Yes
- Not sure

3. Which one of the following best describes your feelings? (Mark one answer.)

- Completely heterosexual (attracted to persons of the opposite sex) Go to question 4 below.
- Mostly heterosexual
- Bisexual (equally attracted to men and women)
- Mostly homosexual
- Completely homosexual (gay/lesbian, attracted to persons of the same sex)
- Not sure

How many people in your family know about your same-sex feelings (parents or stepparents, grandparents, brothers, and sisters)?

- Everyone knows
- Most people know
- Some people know
- A few people know
- No one knows

How many of your friends know about your same-sex feelings?

- Everyone knows
- Most people know
- Some people know
- A few people know
- No one knows

How many people at school know about your same-sex feelings?

- Everyone knows
- Most people know
- Some people know
- A few people know
- No one knows

I wish I were not attracted to the same sex.

- Strongly agree
- Agree
- Mixed/not sure
- Disagree
- Strongly disagree

4. During your life, the person(s) with whom you have had sexual contact is (are):

- I have not had sexual contact with anyone
- Female(s)
- Male(s)
- Female(s) and male(s)

5. In the past year, how often did you go to lesbian, gay, or bisexual social events, cafes, dance clubs, bars, or hung around these places?

- Never
- 1-5 times
- 6-11 times
- 1 time/month
- 2-3 times/month
- 1 time/week
- 2+ times/week

6. In the past year, how often did you go to lesbian, gay, or bisexual meetings or educational events at a community center or other place?

- Never
- 1-5 times
- 6-11 times
- 1 time/month
- 2-3 times/month
- 1 time/week
- 2+ times/week

7. In the past year, how often did you read or watch lesbian, gay, or bisexual magazines, newspapers, books, web sites, videos or movies?

- Never
- 1-5 times
- 6-11 times
- 1 time/month
- 2-3 times/month
- 1 time/week
- 2+ times/week

8. How many of your close friends (people you can confide in) are lesbian, gay, or bisexual?

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 or more

9. I feel uneasy around people who are very open in public about being gay, lesbian, or bisexual.

- Strongly agree
- Agree
- Mixed/Not sure
- Disagree
- Strongly disagree

10. I worry a lot that others might think I am lesbian, gay, or bisexual.

- Strongly agree
- Agree
- Mixed/Not sure
- Disagree
- Strongly disagree

DRUGS AND ALCOHOL

1. During the past year, have you used any of the following drugs? (Mark all that apply.)

- Marijuana Ecstasy (E, X) Heroin Cocaine Crystal Meth Speed Mushrooms LSD

... or any of these drugs without a doctor's prescription? (Mark all that apply.)

- OxyContin Percocet/Percodan Ritalin, Adderall Valium, Xanax, Librium Sleeping pills (Rohypnol, roofies)

I have not taken any of these drugs Other (please specify) _____

2. During the past year, how often did you use any of the following products?

	NEVER	LESS THAN MONTHLY	MONTHLY	WEEKLY	DAILY
Ephedra-containing products (like Metabolife)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Creatine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Amino acids, DHEA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Growth hormone or anabolic/injectable steroids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. Have you ever tried drinking alcohol (beer, wine, or liquor), even a few sips?

- Yes No

On average, in the past year, how often did you drink beer, wine, or liquor?

- Don't drink Less than once a month Less than once a week 1-2 days per week
 3-5 days per week Almost everyday Daily

When you drink alcohol, how much do you usually drink at one time?

- Don't drink alcohol Less than 1 glass/can/drink 1 glass/can/drink
 2 glasses/cans/drinks 3 glasses/cans/drinks 4 glasses/cans/drinks
 5 glasses/cans/drinks 6 or more glasses/cans/drinks

1 drink=
 1 can/bottle of beer
 1 glass of wine
 1 shot of liquor
 1 mixed drink

During the past year, how many times did you drink 4 or more alcohol drinks over a few hours?

- None 1 time 2 times 3-5 times
 6-8 times 9-11 times 12 or more times

They all have the same amount of alcohol.

YOUNG WOMEN'S HEALTH

1. When a doctor or nurse does a pelvic or gynecologic exam, sometimes a small, flat stick or a very small brush is used to scrape the cervix. This is to get a sample of the cells to make sure they are normal. It is called a Pap test.

Have you ever had a Pap test?

- No Not sure Yes → Did you have a Pap test in the past year? Yes No Not sure

2. Have you ever used birth control pills, patch (Ortho-Evra), ring (Nuvaring), Depo Provera or injectable estrogen (Lunelle) for **any** reason (acne, bad cramping, irregular period, birth control)?

- Yes → During the past year did you use birth control pills, patch (Ortho-Evra), ring (Nuvaring) or injectable estrogen (Lunelle) for **any** reason? Yes No Not sure

During the past year, have you used Depo Provera? Yes No Not sure

3. During the past year, have you been pregnant or breast-feeding?

- Yes No → During the past year, have you skipped three or more periods in a row?
 No Yes, but my periods have started again Yes, and I'm still not getting my periods

4. How old were you when you started having menstrual periods?

- Before age 10 10 11 12 13
 14 15 16 17 or older Not yet → Go to Acne section.

5
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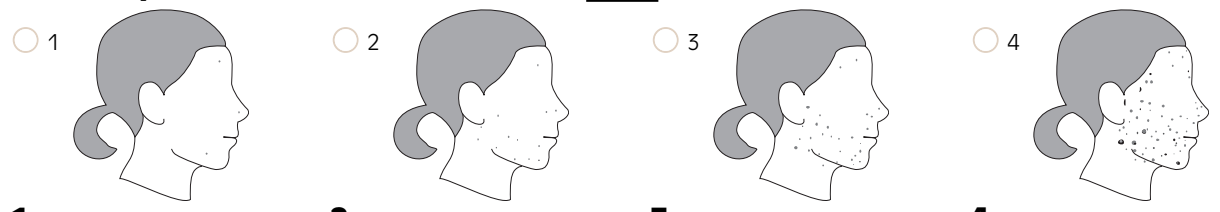
5. What is the current usual length of your menstrual cycle (interval from first day of period to first day of next period)?
 Less than 21 days 21-25 26-31 32-39 40-50 51 or more days or too irregular to estimate

6. What is the current usual pattern of your menstrual cycles (when not pregnant, breast-feeding or using birth control pills)?
 Extremely regular (no more than 1-2 days before or after expected) Very regular (within 3-4 days)
 Regular (within 5-7 days) Usually irregular
 Always irregular No periods

7. How many years after the onset of your menstrual periods did your cycles become regular? (Your cycle is the interval from first day of period to first day of next period.)
 Less than 1 year 1-2 years 3-4 years 5 years or more Still not regular

ACNE

1. How has your acne looked *at its worst ever*?



1. No significant acne

2. Mild acne

3. Moderate acne

4. Severe acne

- inflamed (pink-reddish in color)
- several; all smaller than a pinhead

- inflamed (pink-reddish in color)
- several to many; some pinhead size or larger
- some contain pus or fluid

- inflamed (pink-reddish in color)
- many pinhead size or larger
- some contain pus or fluid
- persistent scarring
- persistent discharge

2. Which of these medications have you ever used for "zits"? (Mark all that apply.)

- Non-prescription skin cream/gels, like Clearasil
- Tretinoin (Retin-A)
- Contraceptive pills or other hormones
- Adapalene (Differin)
- None
- Cleocin-T gel or cream
- Antibiotic pills, like tetracycline, doxycycline, minocycline (Minocin), erythromycin
- Spironolactone (Aldactone)
- Isotretinoin (Accutane)

Please tell us your e-mail address and we'll send updates on what's going on with the study!

Please print neatly and differentiate numbers and letters (e.g., 1 vs l or i, 0 vs O, 5 vs S)

We will not release your e-mail address to anyone!

Do you have any suggestions for the next GUTS survey? We'd love to hear them!

Thank you for completing this survey!

Mail to: Growing Up Today Study
Channing Lab
181 Longwood Ave.
Boston, MA 02115

This is your ID

A	1	1	1	1	1	1	1	1
B	2	2	2	2	2	2	2	2
C	4	4	4	4	4	4	4	4
D	8	8	8	8	8	8	8	8
E	P	P	P	P	P	P	P	P

Photographs courtesy of Getty Images

1 2 3 4 5 6 7 8 9 10 11 12 | 03 04 05

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