COMMENTS	-Affix label here- Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name ________________________M.I.______ Last Name _________________________________
To be completed by Physician Adjudicator: Date Completed: [ ]-[ ]-[ ] (M/D/Y) Adjudicator Code: [ ]	*To be completed by Outcomes Specialist:* Staff person: [ ] Adjudication Case No.: [ ]

Complete this form only if the participant is in the Hormone Replacement Therapy (HRT) component.

1. **Hysterectomy (in HRT only)**

   1.1. Date of hysterectomy: [ ]-[ ]-[ ] (M/D/Y)

2. Type of hysterectomy: ***(Mark the one category that applies best.)***
   - ☐1 Abdominal
   - ☐2 Vaginal

3. Associated surgery: ***(Mark the one category that applies best.)***
   - ☐0 None
   - ☐1 Partial oophorectomy
   - ☐2 One ovary removed
   - ☐3 Bilateral oophorectomy

4. Reason for hysterectomy: ***(Mark the one category that applies best.)***
   - ☐1 Cancer
   - ☐2 Atypical hyperplasia
   - ☐3 Bleeding
   - ☐4 Fibroids (myomas)
   - ☐5 Endometriosis
   - ☐6 Descensus (prolapse)
   - ☐8 Other ***(Specify)***: ____________________________________

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Responsible Adjudicator Signature

NOTE: If this is a hospitalized event, Form 125 - Summary of Hospitalization Diagnosis must be completed and any other WHI outcomes adjudicated.

RV__________KE____________