**COMMENTS**

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<tr>
<td>Clinical Center/ID: __ __ &quot; __ __ __ __ __ __ &quot; __</td>
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<tr>
<td>First Name ___________________ M.I. ______</td>
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<tr>
<td>Last Name ___________________</td>
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To be completed by Physician Adjudicator:

<table>
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<tr>
<th>Date Completed: [<strong>] [</strong>] [<strong>] [</strong>] [<strong>] [</strong>] [__] (M/D/Y)</th>
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<tbody>
<tr>
<td>Adjudicator Code: [<strong>] [</strong>] [<strong>] [</strong>] [<strong>] [</strong>] [__]</td>
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To be completed by Outcomes Specialist:

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<tr>
<th>Staff person: [<strong>] [</strong>] [<strong>] [</strong>] [<strong>] [</strong>] [__]</th>
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<td>Adjudication Case No.: [<strong>] [</strong>] [<strong>] [</strong>] [<strong>] [</strong>] [__]</td>
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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.)*
   
   - [ ] Abdominal
   - [ ] Vaginal

3. Associated surgery: *(Mark the one category that applies best.)*
   
   - [ ] None
   - [ ] Partial oophorectomy
   - [ ] One ovary removed
   - [ ] Bilateral oophorectomy

4. Reason for hysterectomy: *(Mark the one category that applies best.)*
   
   - [ ] Cancer
   - [ ] Atypical hyperplasia
   - [ ] Bleeding
   - [ ] Fibroids (myomas)
   - [ ] Endometriosis
   - [ ] Descensus (prolapse)
   - [ ] Other *(Specify):* ____________________________

_________________________
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 ______