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)***: _____

_____
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_____