



Patient's Name:

Oxford Shoulder Score (OSS)

Shoulder Surgery Questionnaire – Before / after your operation

PROBLEMS WITH YOUR SHOULDER

Tick (✓) one box for every question.

1. During the past 4 weeks...

How would you describe the **worst** pain you had from your shoulder?

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| None | Mild | Moderate | Severe | Unbearable |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

2. During the past 4 weeks...

Have you had any trouble dressing yourself because of your shoulder?

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| No trouble at all | A little bit of trouble | Moderate trouble | Extreme difficulty | Impossible to do |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

3. During the past 4 weeks...

Have you had any trouble getting in and out of a car or using public transport because of your shoulder?

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| No trouble at all | A little bit of trouble | Moderate trouble | Extreme difficulty | Impossible to do |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

4. During the past 4 weeks...

Have you been able to use a knife and fork - at the same time?

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Yes, easily | With little difficulty | With moderate difficulty | With extreme difficulty | No, impossible |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

5. During the past 4 weeks...

Could you do the household shopping on your own?

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Yes, easily | With little difficulty | With moderate difficulty | With extreme difficulty | No, impossible |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

6. During the past 4 weeks...

Could you carry a tray containing a plate of food across a room?

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Yes, easily | With little difficulty | With moderate difficulty | With extreme difficulty | No, impossible |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

7. During the past 4 weeks...Could you brush/comb your hair with the affected arm?

| | | | | |
|--------------------------|---------------------------|--------------------------------|----------------------------|--------------------------|
| Yes, easily | With little difficulty | With moderate difficulty | With extreme difficulty | No, impossible |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

8. During the past 4 weeks...How would you describe the pain you usually had from your shoulder?

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| None | Very mild | Mild | Moderate | Severe |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

9. During the past 4 weeks...Could you hang your clothes up in a wardrobe, using the affected arm?

| | | | | |
|--------------------------|---------------------------|--------------------------------|--------------------------|--------------------------|
| Yes, easily | With little difficulty | With moderate difficulty | With great difficulty | No, impossible |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

10. During the past 4 weeks...

Have you been able to wash and dry yourself under both arms?

| | | | | |
|--------------------------|---------------------------|--------------------------------|----------------------------|--------------------------|
| Yes, easily | With little difficulty | With moderate difficulty | With extreme difficulty | No, impossible |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

11. During the past 4 weeks...How much has pain from your shoulder interfered with your usual work (including housework)?

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Not at all | A little bit | Moderately | Greatly | Totally |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

12. During the past 4 weeks...Have you been troubled by pain from your shoulder in bed at night?

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| No nights | Only 1 or 2 nights | Some nights | Most nights | Every night |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Finally, please check back that you have answered each question.
Thank you very much.**