

# Oxford Shoulder Score (OSS)

English version for the United Kingdom

Prior to completing the Questionnaire please complete the following:-

**Today's Date:**

D	D	M	M	2	0		
				Y	Y	Y	Y

On which side of your body is the affected joint, **for which you are receiving treatment.**

Left

Right

Both

**If you said 'both', please complete the first questionnaire thinking about the right side. A second questionnaire, for the left side, will follow.**

# 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

## 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

## 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

## 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

## 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

## 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

**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.**