



OXFORD ELBOW SCORE

Problems with your elbow

RIGHT
LEFT

✓ tick one box for each question

1 During the past 4 weeks
Have you had any difficulty lifting things in your home, such as putting out rubbish because of your elbow?

No difficulty	Little difficulty	Moderate difficulty	Extreme difficulty	Impossible to do
<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 difficulty carrying bags of shopping because of your elbow problem?

No difficulty	Little difficulty	Moderate difficulty	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 difficulty washing yourself all over because of your elbow problem?

No difficulty	Little difficulty	Moderate difficulty	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 had any difficulty dressing yourself because of your elbow problem?

No trouble At all	Little trouble	Moderate trouble	Extreme difficulty	Impossible to do
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5 During the past 4 weeks
Have you felt that your elbow problem is "controlling your life"?

No, not at all	occasionally	Some days	Most days	Every day
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6 During the past 4 weeks
How much has your elbow problem been "on your mind"??

Not at all	A little of occasionally	Some of the days	Most of the time	All of the time
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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- 7** During the past 4 weeks
Have you been troubled by pain from your elbow in bed at nights?
- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| No nights | Only
1-2 nights | Some nights | Most nights | Every nights |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- 8** During the past 4 weeks
How often has your elbow problem interfered with your sleeping?
- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Not at all | Occasionally | Some days | Most days | All of the time |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- 9** During the past 4 weeks
How much pain from your elbow interfered with your part in leisure activities that you enjoy doing?
- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Not at all | A little bit | Moderately | Greatly | Totally |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- 10** During the past 4 weeks
Has your elbow problem limited your ability to take part in leisure activities that you enjoy doing?
- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Not at all | Occasionally | Some days | Most days | All of the time |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- 11** During the past 4 weeks
How would you describe the worst pain you have had from your elbow?
- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| None | Mild | Moderate | Severe | Unbearable |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- 12** During the past 4 weeks
How would you describe the pain you usually had from the elbow?
- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| None | Mild | Moderate | Severe | Unbearable |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |