

Study Number:

# UK Rotator Cuff Surgery Trial



**CONFIDENTIAL**

## **UKUFF SHOULDER TRIAL**

### **PATIENT ASSESSMENT**

**8, 12, 24 MONTHS POST RANDOMISATION**

Thank you for helping us with our research into rotator cuff tears.  
We would be very grateful if you could complete and return this questionnaire in the enclosed  
freepost envelope.

## HOW TO FILL IN THIS QUESTIONNAIRE

Most questions can be answered by putting numbers or a tick in the appropriate box or boxes. Please print your answers carefully within the boxes like this:

2	7
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OR

M	I	K	E
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OR

√
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Please try to complete the whole questionnaire.

There are no right or wrong answers.

Sometimes the box you tick tells you to skip forward so that you miss out questions which do not apply to you.

In some questions, we would like you to think about different time periods, such as during the last 4 weeks or during the last 8, 12, 24 months. Please check the time periods carefully.

Some of the questions ask for answers in your own words, please write these in the boxes provided.

**Thank you for your help.**

## Section 1 – Shoulder Problems And Treatments

Please tick **ONE** box for **EACH** question

2. Have you been unwell for a reason other than your shoulder (during the past 8 months)?

Yes  No  **IF NO, GO TO QUESTION 3**

If YES, 2a. What was the reason? .....

.....

If YES, 2b. Were you admitted to hospital? Yes  No

If YES, 2c. Did you have an operation? Yes  No

3. How are the problems related to your shoulder NOW, compared with 8 months ago (at the start of this study)?

Much better

Slightly better

No change

Slightly worse

Much worse

4. Overall, how pleased are you with your shoulder symptoms so far?

Very Pleased

Fairly pleased

Not very pleased

Very disappointed

5. Are you currently employed? Yes No

If YES, 5a. Are you currently 'off sick' or working reduced duties because of your shoulder?

Yes 'off-sick'

Yes working reduced hours/duties

No working usual hours/duties

## Section 2 – Questions About Your Shoulder

Please tick **ONE** box for **EACH** question

**During the past 4 weeks**

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

None

Mild

Moderate

Severe

Unbearable

**During the past 4 weeks**

2. 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

**During the past 4 weeks**

3. 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

**During the past 4 weeks**

4. 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

**During the past 4 weeks ...**  
**Please tick ONE box for EACH question**

**During the past 4 weeks**

**5. Could you do the household shopping on your own?**

Yes,  
easily

With little  
difficulty

With moderate  
difficulty

With extreme  
difficulty

No,  
impossible

**During the past 4 weeks**

**6. 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

**During the past 4 weeks**

**7. Could you brush/comb your hair with the affected arm?**

Yes,  
easily

With little  
difficulty

With moderate  
difficulty

With extreme  
difficulty

No,  
impossible

**During the past 4 weeks**

**8. How would you describe the pain you usually had from your shoulder?**

None

Very mild

Mild

Moderate

Severe

**During the past 4 weeks ...**  
**Please tick ONE box for EACH question**

**During the past 4 weeks**

**9. 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

**During the past 4 weeks**

**10. 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

**During the past 4 weeks**

**11. How much has pain from your shoulder interfered with your usual work (including housework)?**

Not at all

A little bit

Moderately

Greatly

Totally

**During the past 4 weeks**

**12. 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

## Section 3 – Shoulder Pain and Disability

Please ring round **ONE** number to **EVERY** question where  
0 = no pain and 10 = worst pain imaginable

### PAIN SCALE DURING THE PAST WEEK

How severe is your shoulder pain .....

1. At its worst?	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable
2. When lying on involved side?	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable
3. Reaching for something on a high shelf?	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable
4. Touching the back of your neck?	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable
5. Pushing with the involved arm?	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable

Please ring round **ONE** number to **EVERY** question where  
0 = no difficulty and 10 = so difficult required help

### DISABILITY SCALE DURING THE PAST WEEK

How much difficulty do you have.....

1. Washing your hair?	No difficulty	0	1	2	3	4	5	6	7	8	9	10	So difficult required help
2. Washing your back?	No difficulty	0	1	2	3	4	5	6	7	8	9	10	So difficult required help
3. Putting on an undershirt or pullover sweater?	No difficulty	0	1	2	3	4	5	6	7	8	9	10	So difficult required help
4. Putting on a shirt that buttons down the front?	No difficulty	0	1	2	3	4	5	6	7	8	9	10	So difficult required help





## Your Health Today

Please indicate which statement describes your own health state today.

Please tick **ONE** box for **EACH** question.

### a) Mobility

I have no problems in walking about

I have some problems in walking about

I am confined to bed

### b) Self-care

I have no problems with self care

I have some problems with washing or dressing myself

I am unable to wash and dress myself

### c) Usual Activities

I have no problems in performing my usual activities  
(eg: work, study, housework, leisure activity)

I have some problems in performing my usual activities

I am unable to perform my usual activities

### d) Pain / Discomfort

I have no pain or discomfort

I have moderate pain or discomfort

I have extreme pain or discomfort

### e) Anxiety / Depression

I am not anxious or depressed

I am moderately anxious or depressed

I am extremely anxious or depressed

**Finally:**

**Date you filled in this questionnaire**      D D    M M    Y Y Y Y  
   /  /

## THANK YOU

Thank you for completing this questionnaire. The information you have given us will be extremely useful.

It will be treated with the strictest confidence and kept securely.

Please send the questionnaire back to us in Aberdeen in the envelope provided.

**Please could you inform us of any changes to your phone number:**

**And inform us of any changes to your contact details:** .....

.....  
.....

## Thank you again for your help.

If you would like any further information or have any queries about the study, please contact:

The UKUFF Study Office in Aberdeen 

or visit our website at [www.chartrials.abdn.ac.uk/ukuff](http://www.chartrials.abdn.ac.uk/ukuff)

This study is taking place in centres across the UK but the questionnaires are being processed in Aberdeen at the Centre for Healthcare Randomised Trials (CHaRT), Health Services Research Unit, University of Aberdeen, Health Sciences Building, Foresterhill, ABERDEEN, AB25 2ZD