MEDICAL EXAMINATION

1. Name & Surname: _____

2. Date of Birth: _____ Height: _____ Weight:_____

3. Gender: ☐ Male ☐ Female 4. ID Number: _____

5. Highest Education Attained: _____

6. Previous Record: Number of fights:_____

Number of defeats:_____

Number of knock-outs sustained by boxer:_____

7. Any history of mental illness	YES ☐	NO ☐
8. Any previous or current chronic illness and use of medication?*	YES ☐	NO ☐
9. Any history of eye problems, relating to illness otherwise	YES ☐	NO ☐
10. Any history of previous illness, injury or	YES ☐	NO ☐

If yes to any of the above, please give details: _____

*** Despite any confirmation of chronic illness and use of medication on this form, the same will still need to be declared in the event of anti-doping tests and/or at any other time required to do so.**

FOR DOCTORS USE ONLY				
Examinations:	RIGHT		LEFT	
PUPILS: Light	Normal	Abnormal	Normal	Abnormal
Adaption	Normal	Abnormal	Normal	Abnormal
	/20	/6	/20	/6
VISION:	Normal	Abnormal	Normal	Abnormal
FUNDI:	Normal	Abnormal	Normal	Abnormal
REFLEXES: Knee:	Normal	Abnormal	Normal	Abnormal
Ankle:	Normal	Abnormal	Normal	Abnormal
Biceps:	Normal	Abnormal	Normal	Abnormal
Triceps:	Normal	Abnormal	Normal	Abnormal
Abdominal:	Normal	Abnormal	Normal	Abnormal
	Normal	Abnormal	Normal	Abnormal
VOICE/SPEECH:		Abnormal	Normal	

OTHER NEUROLOGICAL SIGNS: _____

PULSE/min _____

BLOOD PRESSURE _____

HEART:	Abnormal	Normal
LUNGS:	Abnormal	Normal
EARS:	Abnormal	Normal
NOSE/THROAT:	Abnormal	Normal
ABDOMEN/HERNIA:	Abnormal	Normal
UPPER EXTREMITIES:	Abnormal	Normal
LOWER EXTREMITIES:	Abnormal	Normal
URINE ANALYSIS: ALBUMEN	Abnormal	Normal
SUGAR	Abnormal	Normal
BLOOD	Abnormal	Normal
PREGNANCY TEST:	Positive	Negative

If any finding is abnormal, please give details: _____

_____

Doctor's Name & Surname: _____

Address: _____ Practise No.: _____

Date of Examination: _____ Doctor's Signature: _____

I, the undersigned, _____, hereby confirm that the information herein before recorded and supplied by me is in all respects true and correct.

Boxer's Signature: _____ Date: _____

Witnesses:

1. _____ Signature: _____

2. _____ Signature: _____

Doctor's Stamp

_____