



Pre-bout Medical Questionnaire for Male Boxers

Date: \_\_\_\_\_ Site: \_\_\_\_\_

Questions for Boxer:

Name: \_\_\_\_\_

(Please Print)

Have you had any of the following symptoms lately?

- 1. Headaches Yes [ ] No [ ]
2. Dizziness Yes [ ] No [ ]
3. Nausea or vomiting Yes [ ] No [ ]
4. Double or blurred vision Yes [ ] No [ ]
5. Have you taken any medication within the last 90 days Yes [ ] No [ ]
If yes what kind \_\_\_\_\_

- 6. Do you have any body piercing Yes [ ] No [ ]
7. In the last 12 months, have you had close contact with any person who has Hepatitis or HIV Yes [ ] No [ ]

If you think you may be infected with Hepatitis or HIV you should not box

IN THE LAST 30 DAYS

- 8. Have you participated in any contact sport (including boxing?) Yes [ ] No [ ]
9. Did you sustain any injury ? Yes [ ] No [ ]

If Yes what type of injury \_\_\_\_\_

- 10. Did you receive any suspension or removal from play? Yes [ ] No [ ]
11. Have you sustained a concussion in the last 60 days? Yes [ ] No [ ]

If you do not understand any questions please inform the Medical Doctor

Boxer Signature: \_\_\_\_\_

Questions for Coach:

Name: \_\_\_\_\_

(Please Print)

Have you noticed any decrease in function or negative change in your boxer regarding the following?

- 1. Attention or concentration: Yes [ ] No [ ]
2. Memory Yes [ ] No [ ]
3. Speech Yes [ ] No [ ]
4. Behavior Yes [ ] No [ ]
5. Sparring (quickness) Yes [ ] No [ ]

In the past 30 days has your boxer sustained injury or removal from play in any contact sport including boxing? Yes [ ] No [ ]

Coach Signature: \_\_\_\_\_

Medical Doctor - Name: \_\_\_\_\_ License # \_\_\_\_\_
(Please Print)

Medical Doctor - Signature: \_\_\_\_\_