CANADIAN AMATEUR BOXING ASSOCIATION

Pre-bout Medical Questionnaire for Female Boxers

Date: ____________________________ Site: ____

Questions for Boxer: Name: ______________________________________

(Please Pint)

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. Are you pregnant Yes [ ] No [ ]
7. When was your last menstruation? Date: ________________________________
8. Did you do a pregnancy test Yes [ ] Negative [ ] Positive [ ] No [ ]

If you even think you might be pregnant you should not box.

9. Have you noted any menstrual abnormality recently such as an absent menses, abnormal vaginal bleeding with or without pelvic pain / tenderness not consistent with your normal menstrual cycle & patterns? Yes [ ] No [ ]
10. Have you noted any breast masses, bleeding or other breast dysfunction Yes [ ] No [ ]
11. Have you had breast augmentation implants or tissue transfer Yes [ ] No [ ]
12. Do you have any body piercing Yes [ ] No [ ]
13. In the last 12 months, have you had close contact with any
14. 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 (As per Boxing Ontario protocol)

15. Have you participated in any contact sport (including boxing? Yes [ ] No [ ]
16. Did you sustain any injury ? Yes [ ] No [ ]
    If Yes what type of injury ____
17. Did you receive any suspension or removal from play? Yes [ ] No [ ]
18. 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: ____