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 history of eye problems, relating to illness otherwise YES ☐ NO ☐

9. Any history of previous illness or injury YES ☐ NO ☐

If yes to any of the above give details: _____

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:

_____