



**Pre-bout Medical Questionnaire for Male Boxers**

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

**Questions for Coach:**

Name: \_\_\_\_\_  
(Please Print)

Have you noticed any changes 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 [ ] |

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

**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 [ ] |
| 8. If you think you may be infected with Hepatitis or HIV you should not box                  |         |        |

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

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

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

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