



SVENSKA PROFFSBOXNINGSKOMMISSIONEN  
SWEDISH PROFESSIONAL BOXING COMMISSION  
AFFILIATED TO EUROPEAN BOXING UNION (EBU)

## MEDICAL EXAMINATION FOR PROFESSIONAL BOXERS

### QUESTIONS TO BE ANSWERED BY EXAMINED BOXER

Family name: \_\_\_\_\_

First name(s): \_\_\_\_\_

Security number: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number: \_\_\_\_\_

E-mail: \_\_\_\_\_

Have you held a license before? Yes \_\_\_ No \_\_\_

In which country/countries: \_\_\_\_\_

### BOXING CAREER

Record of contest, professional bouts: Won \_\_\_ Lost \_\_\_ Draws \_\_\_

Lost by KO:  
Dates for all losses: \_\_\_\_\_

Record of contest, amateur bouts: Won \_\_\_ Lost \_\_\_ Draws \_\_\_

Lost by KO:  
Dates for all losses: \_\_\_\_\_

Lost by TKO:  
Dates for all losses: \_\_\_\_\_

Lost by RSC(H):  
Dates for all losses: \_\_\_\_\_

### BOUNDS IN OTHER COMBAT SPORTS

Number of contests: \_\_\_\_\_

Lost by KO:  
Dates for all losses: \_\_\_\_\_

Lost by TKO/ RSC(H):  
Dates for all losses: \_\_\_\_\_

## HEALTH QUESTIONS

Are you in good health \_\_\_\_\_  
 Any current infections \_\_\_\_\_  
 Did you have any hard blows to the head, headache, vomit, balance problems,  
 unusual weakness, vertigo, fainting during the last week.  
 \_\_\_\_\_

Have you suffered at any time from the following symptoms, injuries or illnesses (if so give a full detailed description, results of investigations and where they were done)

Amnesia \_\_\_\_\_  
 Severe headache \_\_\_\_\_  
 Seizures \_\_\_\_\_  
 Blackouts \_\_\_\_\_  
 Paralysis \_\_\_\_\_  
 Neurological disorder \_\_\_\_\_  
 Visual disturbances \_\_\_\_\_  
 Do you wear glasses? \_\_\_\_\_ Contact lenses \_\_\_\_\_  
 Hearing problems \_\_\_\_\_  
 Heart disease, hypertonia \_\_\_\_\_  
 Severe joint problems or fractures \_\_\_\_\_  
 Problems with hands \_\_\_\_\_  
 Severe problems with the nose or breathing \_\_\_\_\_  
 Asthma, bronchitis, pneumonia, tuberculosis \_\_\_\_\_  
 Chronic inflammations as rheumatism, colitis, Mb Crohn \_\_\_\_\_  
 Problems with stomach, intestines, liver, gall bladder, kidneys \_\_\_\_\_  
 Hernia \_\_\_\_\_  
 Metabolic disturbances as diabetes mellitus \_\_\_\_\_  
 Hematuria \_\_\_\_\_  
 Skin diseases, allergies \_\_\_\_\_  
 Other severe illnesses \_\_\_\_\_

Other severe injuries \_\_\_\_\_

Previous operations \_\_\_\_\_

Have you been attending a doctor regularly for any illness or trauma \_\_\_\_\_

Do you medicate regularly: If so what \_\_\_\_\_

Date \_\_\_\_\_

Signature of boxer \_\_\_\_\_

Clarification of signature \_\_\_\_\_

Date \_\_\_\_\_

Signature of doctor \_\_\_\_\_

Clarification of signature \_\_\_\_\_

## EXAMINATION BY DOCTOR

Body inspection (including overweight) \_\_\_\_\_  
 Height (cm) \_\_\_\_\_  
 Weight (kg) \_\_\_\_\_  
 Urine sample (taken always): \_\_\_\_\_  
 Latest MR brain: \_\_\_\_\_  
 Latest blood sample: \_\_\_\_\_  
 HIV: \_\_\_\_\_  
 Hepatis B and C: \_\_\_\_\_

## EYES

Condition of skin around eyes \_\_\_\_\_  
 Visual standard (without glasses): \_\_\_\_\_  
 Right eye \_\_\_\_\_  
 Left eye \_\_\_\_\_  
 State of Cornea \_\_\_\_\_  
 Visual fields (Donders test) \_\_\_\_\_  
 Ocular movements \_\_\_\_\_  
 Pupil's reaction to light \_\_\_\_\_  
 Anisocoria \_\_\_\_\_  
 Fundi \_\_\_\_\_  
 Nystagmus \_\_\_\_\_

## MOUTH AND THROAT

Throat \_\_\_\_\_  
 Nose \_\_\_\_\_  
 Teeth \_\_\_\_\_  
 Dental condition \_\_\_\_\_

## EARS

Tympanic membranes \_\_\_\_\_  
 Right \_\_\_\_\_  
 Left \_\_\_\_\_  
 Hearing right ear \_\_\_\_\_  
 Hearing left ear \_\_\_\_\_

## HEART

Heart sounds \_\_\_\_\_  
 Murmurs \_\_\_\_\_  
 Pulse \_\_\_\_\_  
 Blood pressure \_\_\_\_\_

## LUNGS

ENLARGEMENT OF LIVER OR SPLEEN \_\_\_\_\_

ARMS AND LEGS

Abnormalities \_\_\_\_\_

Injuries \_\_\_\_\_

Date \_\_\_\_\_

Signature of examining doctor \_\_\_\_\_

Clarification of signature \_\_\_\_\_