

**MANITOBA BOXING COMMISSION
COMPLETE PHYSICAL EXAMINATION**

Legal Name: _____ Ring Name: _____
 Address _____
 Medical Ins. No.: _____ Date of Birth (D/M/Y) _____

Boxing Record | No. of bouts _____ WON _____ LOST _____ DRAW _____ | Last bout (D/M/Y) _____
 Results of last 3 bouts (1) _____ (2) _____ (3) _____ | No. of times knocked unconscious (career) _____

PAST MEDICAL HISTORY (to be completed by boxer)

	Yes	No		Yes	No		Yes	No
1. Problems/injuries to eyes	<input type="checkbox"/>	<input type="checkbox"/>	8. Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	15. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
2. Migraines	<input type="checkbox"/>	<input type="checkbox"/>	9. Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	16. Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>
3. Concussion	<input type="checkbox"/>	<input type="checkbox"/>	10. Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	17. Pinched nerve	<input type="checkbox"/>	<input type="checkbox"/>
4. Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	11. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	18. Seizures	<input type="checkbox"/>	<input type="checkbox"/>
5. Facial injuries	<input type="checkbox"/>	<input type="checkbox"/>	12. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	19. Broken bone(s)	<input type="checkbox"/>	<input type="checkbox"/>
6. Thyroid disorders	<input type="checkbox"/>	<input type="checkbox"/>	13. Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	20. Previous surgery	<input type="checkbox"/>	<input type="checkbox"/>
7. Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	14. Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	21. Other medical problems	<input type="checkbox"/>	<input type="checkbox"/>

If answered yes above, please elaborate: _____

Present medication(s) (list): _____ Allergies: _____

FAMILY HISTORY (to be completed by boxer)

	Yes	No		Yes	No		Yes	No
1. Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	5. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	9. Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>
2. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	6. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	10. Seizures	<input type="checkbox"/>	<input type="checkbox"/>
3. Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>	7. Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	11. Death @ young age	<input type="checkbox"/>	<input type="checkbox"/>
4. Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	8. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	12. Sudden death during exercise	<input type="checkbox"/>	<input type="checkbox"/>
						13. Other medical problems	<input type="checkbox"/>	<input type="checkbox"/>

If answered yes above, please elaborate: _____

REVIEW OF SYSTEMS/RECENT PROBLEMS (to be completed by the physician)

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GENERAL APPEARANCE: _____ B.P. (sitting) _____ (supine) _____

PULSE _____ beats/min REGULAR IRREGULAR WEIGHT _____ HEIGHT _____

ENT	NORMAL: _____ ABNORMAL: _____ COMMENTS: _____ _____
NECK (thyroid, larynx, masses)	NORMAL: _____ ABNORMAL: _____ COMMENTS: _____ _____
LUNGS (breath sounds, chest wall, ribs)	NORMAL: _____ ABNORMAL: _____ COMMENTS: _____ _____
CV (heart sounds, murmurs, pulses)	NORMAL: _____ ABNORMAL: _____ COMMENTS: _____ _____
Abdominal/ inguinal	NORMAL: _____ ABNORMAL: _____ COMMENTS: _____ _____
Rectal/ genitalia	NORMAL: _____ ABNORMAL: _____ COMMENTS: _____ _____
Spine/ pelvis	NORMAL: _____ ABNORMAL: _____ COMMENTS: _____ _____
Joints/ extremities	NORMAL: _____ ABNORMAL: _____ COMMENTS: _____ _____

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MENTAL STATUS	Normal: _____ Abnormal: _____ Comments: _____																								
CRANIAL NERVES	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 10%; text-align: center;">Normal</th> <th style="width: 10%; text-align: center;">Abnormal</th> <th style="width: 20%; text-align: left;">Comments:</th> </tr> </thead> <tbody> <tr> <td>Pupillary reaction</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Extra-ocular movements</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Facial symmetry</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Facial Sensation</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Gag reflex/tongue</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>_____</td> </tr> </tbody> </table>		Normal	Abnormal	Comments:	Pupillary reaction	<input type="checkbox"/>	<input type="checkbox"/>	_____	Extra-ocular movements	<input type="checkbox"/>	<input type="checkbox"/>	_____	Facial symmetry	<input type="checkbox"/>	<input type="checkbox"/>	_____	Facial Sensation	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gag reflex/tongue	<input type="checkbox"/>	<input type="checkbox"/>	_____
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MOTOR FUNCTION	Normal: _____ Abnormal: _____ Comments: _____																								
SENSORY FUNCTION	Normal: _____ Abnormal: _____ Comments: _____																								
COORDINATION (finger to nose, rapid successive mvts, heel to shin)	Normal: _____ Abnormal: _____ Comments: _____																								
GAIT/ RHOMBERG	Normal: _____ Abnormal: _____ Comments: _____																								
REFLEXES (sup. and deep/ Babinski)	Normal: _____ Abnormal: _____ Comments: _____																								

I hereby certify that I have examined _____
 (Print full legal name and professional names)
 on this date (d) _____ (m) _____ (y) _____

- There are no abnormalities on his/her physical examination, that contraindicate participation in boxing at this time.
- There are abnormalities on his/her physical examination, that contraindicate participation in boxing at this time.

Specify: _____

Recommendations: _____

Name of Physician: _____ Office address: _____
 Signature: _____ Tel. _____ Fax _____