



Pre-bout Medical Questionnaire for Female 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. 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 person who has Hepatitis or HIV | Yes [] | No [] |
| 14. 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: _____