NEPAL PROFESSIONAL BOXING COMMISSION

PHYSICAL EXAMINATION REPORT/4MM

Boxer Name _____ Ring Name _____

Passport or ID No. _____ Date of Birth _____

Address: _____

PHYSICAL HISTORY: Has applicant ever had any of the following conditions

❑ Fainting spells	❑ Rupture (Hernia)	❑ Convulsions (fits)	❑ Shortness of breath
❑ Operations	❑ Rheumatism	❑ Swollen	❑ Bleeding Disorder
❑ Chest pains/RA	❑ Diabetes	❑ Chronic cough	❑ Spitting of blood
❑ Frequent headache	❑ Cerebral hemorrhage or any other serious head injury		

Number of knockouts received _____ Date of last knockout_____

Longest duration of unconsciousness_____

Length of time before resuming boxing or MMA after last knockout _____

Ever knocked unconscious in other sport or in any other way ❑Yes ❑No

If yes, explain_____

Amateur boxing record	Wins _____	Losses _____	Draws _____
Professional boxing record	Wins _____	Losses _____	Draws _____
Amateur MMA record	Wins _____	Losses _____	Draws _____
Professional MMA record	Wins _____	Losses _____	Draws _____

PHYSICAL EXAMINATION

General appearance: Height: _____ Weight: _____ Temperature: _____

Disabling Scars: Mouth: _____ Teeth: _____ Tonsils: _____ Neck: _____

Did have any episodes of the following for the pass two week?

1. Fever ❑Yes ❑No
2. Loose bowel movement ❑Yes ❑No
3. Severe coughing ❑Yes ❑No
4. Headache ❑Yes ❑No
5. Dizziness ❑Yes ❑No
6. Blurred Vision ❑Yes ❑No
7. Trouble Reading ❑Yes ❑No
8. Double vision ❑Yes ❑No
9. Do you see dark spots or bright lights ❑Yes ❑No

Have you been hospitalized for the past month ❑Yes ❑No

If yes, give detail _____

Have you had any surgery for the past two weeks ❑Yes ❑No

If yes, give detail _____

Have you been involved in any vehicular accidents in the past month ❑Yes ❑No

If yes, give detail _____

Have you been tested positive for prohibited drug ❑Yes ❑No

If yes, give detail _____

FOR FEMALE BOXERS

Last menstrual period _____

Pregnancy history _____

History of surgery or breast implants ❑Yes ❑No

If yes, give detail _____

Blood pressure _____ Heart Rate _____

Respiratory Rate _____ Temp_____

Eyes/Ears/Nose/Throat: _____

NECK: _____

CHEST/ LUNGS: _____

CARDIOVASCULAR: ABDOMEN: _____

EXTREMITIES: _____

CNS: _____

Cerebral: _____

Cranial Nerves Motor: _____

Reflexes: _____

Cerebellar: _____

_____ _____

Boxer's Signature Date

_____

Doctor