# History and Physical Examination Record for License as a Boxer

## SECTION 1 — TO BE COMPLETED BY BOXER

### Personal History

1. **LEGAL NAME**
2. **RING NAME**
3. **STREET ADDRESS (HOME)**
4. **DATE OF BIRTH**
5. **COUNTRY OF BIRTH**
6. **MANAGER’S NAME**
7. **TRAINER’S NAME**
8. **SEX** □ MALE □ FEMALE
9. **PRESENT WEIGHT DIVISION**
10. **NUMBER OF YEARS YOU HAVE BEEN BOXING**
11. **YOUR AGE AT FIRST FIGHT**
12. **PROFESSIONAL BOXING RECORD** *(WON LOST DRAW)*
13. **NUMBER OF AMATEUR FIGHTS**
14. **DATE OF LAST BOUT**
15. **OUTCOME**
16. **Elementary School**
17. **High School**
18. **College**

### Boxing History

19. **PROFESSIONAL BOXING RECORD** *(WON LOST DRAW)*
20. **AMATEUR BOXING RECORD** *(WON LOST DRAW)*
21. **NUMBER OF AMATEUR FIGHTS**
22. **DATE OF LAST BOUT**
23. **OUTCOME**

### Medical History

24. **Gym name, address and telephone #:**

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**New York State**
**DEPARTMENT OF STATE**
**STATE ATHLETIC COMMISSION**
123 William Street
New York, NY 10038-3804

Telephone: (212) 417-5700
www.dos.ny.gov/athletic
32. Have you ever had epilepsy (convulsions or fits)?  
☐ YES  ☐ NO

33. Have you ever suffered a sudden loss of vision?  
☐ YES  ☐ NO

34. Do you suffer from blurred, defective or double vision?  
☐ YES  ☐ NO

35. Have you ever suffered from a ringing or buzzing noise in your ears?  
☐ YES  ☐ NO

36. Have you ever suffered from decreased hearing?  
☐ YES  ☐ NO

37. Do you have a well fitted mouthpiece?  
☐ YES  ☐ NO

38. Do you have any allergies?  
*If YES, explain: ___________________________  
☐ YES*  ☐ NO

39. Do you suffer from shortness of breath or irregular beating of the heart?  
☐ YES  ☐ NO

40. Do you smoke?  
☐ YES  ☐ NO

41. Do you suffer pain or pressure (heaviness) in the chest?  
☐ YES  ☐ NO

42. Have you ever been told that you have heart disease?  
☐ YES  ☐ NO

43. Have you ever coughed up blood or been told that you have lung disease?  
☐ YES  ☐ NO

44. Do you have a cough or wheezing?  
☐ YES  ☐ NO

45. Have you ever been told that you have an ulcer or any other abdominal disease?  
☐ YES  ☐ NO

46. Have you ever suffered from any bone-joint disease?  
☐ YES  ☐ NO

47. Have you ever suffered from any back, neck, shoulder, arm or leg injuries?  
☐ YES  ☐ NO

48. Do you have any difficulties with bowel movements or urination?  
☐ YES  ☐ NO

49. Have you ever been treated for venereal disease (e.g., syphilis, gonorrhea)?  
☐ YES  ☐ NO

50. Have you ever had any major illness or surgical operation?  
☐ YES  ☐ NO

51. Have you ever been hospitalized?  
☐ YES  ☐ NO

52. Have you seen a doctor, dentist or any health professional in the past year?  
☐ YES  ☐ NO

53. Do you or any member of your family have sickle cell anemia?  
☐ YES  ☐ NO

54. Has any member of your family had any neurological or brain disorders?  
☐ YES  ☐ NO

55. Have you any other information concerning your health — past and present —  
☐ YES  ☐ NO

56. which has not been covered by the above questions?  
☐ YES  ☐ NO

Comments, if any: ___________________________

Applicant Certification — I hereby certify that the above statements are true and correct to the best of my knowledge and belief. I further understand that all statements and information supplied by me are made under the penalty of perjury and, if untrue and not informative, will lead to penalty and/or suspension.

X

Applicant Signature

Date

X

Physician’s Signature

Date

Reviewed by (Physician)

Date
### VITAL SIGNS

<table>
<thead>
<tr>
<th>A) BLOOD PRESSURE</th>
<th>B) PULSE (AT REST)</th>
<th>C) PULSE (AFTER 20 HOPS)</th>
<th>D) PULSE (2 MINUTES AFTER EXERCISE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ NORMAL</td>
<td>□ ABNORMAL</td>
<td>□ NOT EXAMINED</td>
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<tr>
<td>COMMENT</td>
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### HEAD AND FACE (Describe scars, swelling, tenderness, etc.)

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<tr>
<th>□ NORMAL</th>
<th>□ ABNORMAL</th>
<th>□ NOT EXAMINED</th>
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### EYES

<table>
<thead>
<tr>
<th>A) RETINA</th>
<th>□ NORMAL</th>
<th>□ ABNORMAL</th>
<th>□ NOT EXAMINED</th>
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</thead>
<tbody>
<tr>
<td>B) CORNEA AND CONJUNCTIVEA</td>
<td>□ NORMAL</td>
<td>□ ABNORMAL</td>
<td>□ NOT EXAMINED</td>
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<tr>
<td>C) VISUAL AUCITY (SNeLEN CHART)</td>
<td>□ NORMAL</td>
<td>□ ABNORMAL</td>
<td>□ NOT EXAMINED</td>
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</table>

### EARS (Including tympanic membrane, external auditory canals, auditory acuity for conversational voice)

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<thead>
<tr>
<th>□ NORMAL</th>
<th>□ ABNORMAL</th>
<th>□ NOT EXAMINED</th>
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### NOSE

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<tr>
<th>□ NORMAL</th>
<th>□ ABNORMAL</th>
<th>□ NOT EXAMINED</th>
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### OROPHARYNX

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<tr>
<th>□ NORMAL</th>
<th>□ ABNORMAL</th>
<th>□ NOT EXAMINED</th>
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</table>

### NECK

<table>
<thead>
<tr>
<th>□ NORMAL</th>
<th>□ ABNORMAL</th>
<th>□ NOT EXAMINED</th>
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</table>

### LUNGS

<table>
<thead>
<tr>
<th>□ NORMAL</th>
<th>□ ABNORMAL</th>
<th>□ NOT EXAMINED</th>
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</table>

### THORAX/ CHEST

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<thead>
<tr>
<th>□ NORMAL</th>
<th>□ ABNORMAL</th>
<th>□ NOT EXAMINED</th>
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### HEART

<table>
<thead>
<tr>
<th>□ NORMAL</th>
<th>□ ABNORMAL</th>
<th>□ NOT EXAMINED</th>
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</table>

### ABDOMEN and INGUINAL AREA

<table>
<thead>
<tr>
<th>□ NORMAL</th>
<th>□ ABNORMAL</th>
<th>□ NOT EXAMINED</th>
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</thead>
<tbody>
<tr>
<td>Section</td>
<td>Details</td>
<td>Status Options</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td>---------------</td>
</tr>
<tr>
<td>12. BACK and SPINE</td>
<td>□ NORMAL □ ABNORMAL □ NOT EXAMINED</td>
<td></td>
</tr>
<tr>
<td>13. EXTREMITIES/MUSCULOSKELETAL SYSTEM</td>
<td>□ NORMAL □ ABNORMAL □ NOT EXAMINED</td>
<td></td>
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<tr>
<td>14. SKIN</td>
<td>□ NORMAL □ ABNORMAL □ NOT EXAMINED</td>
<td></td>
</tr>
<tr>
<td>15. LYMPHATIC SYSTEM</td>
<td>□ NORMAL □ ABNORMAL □ NOT EXAMINED</td>
<td></td>
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<tr>
<td>16. NERVOUS SYSTEM — CRANIAL NERVES</td>
<td>□ NORMAL □ ABNORMAL □ NOT EXAMINED</td>
<td></td>
</tr>
<tr>
<td>A) VISUAL FIELD</td>
<td>□ NORMAL □ ABNORMAL □ NOT EXAMINED</td>
<td></td>
</tr>
<tr>
<td>B) PUPILLARY REACTION (also, NOTE ANY PTOSIS)</td>
<td>□ NORMAL □ ABNORMAL □ NOT EXAMINED</td>
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<tr>
<td>C) EXTRAOCULAR MOVEMENTS (also NOTE NYSTAGMUS)</td>
<td>□ NORMAL □ ABNORMAL □ NOT EXAMINED</td>
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<tr>
<td>D) FACIAL SYMMETRY</td>
<td>□ NORMAL □ ABNORMAL □ NOT EXAMINED</td>
<td></td>
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<tr>
<td>E) GAG REFLEX and TONGUE</td>
<td>□ NORMAL □ ABNORMAL □ NOT EXAMINED</td>
<td></td>
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<tr>
<td>17. MOTOR FUNCTION</td>
<td>□ NORMAL □ ABNORMAL □ NOT EXAMINED</td>
<td></td>
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<tr>
<td>18. COORDINATION (Finger to Nose, Heel to Knee — rapid successive movements)</td>
<td>□ NORMAL □ ABNORMAL □ NOT EXAMINED</td>
<td></td>
</tr>
<tr>
<td>19. GAIT/ROMBERG</td>
<td>□ NORMAL □ ABNORMAL □ NOT EXAMINED</td>
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<tr>
<td>20. REFLEXES</td>
<td>□ NORMAL □ ABNORMAL □ NOT EXAMINED</td>
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</table>
21. MENTAL STATUS

A. ORIENTATION (1 POINT EACH)
   MONTH .................................................... 0 1
   DATE ................................................... 0 1
   DAY OF WEEK ........................................... 0 1
   YEAR ................................................... 0 1
   TIME (WITHIN ONE HOUR) .............................. 0 1

B. IMMEDIATE MEMORY (1 POINT FOR EACH CORRECT; TOTAL OVER 3 TRIALS)
   LIST TRIAL 1 TRIAL 2 TRIAL 3
   CHAIR
   BLUE
   ORANGE
   PENCIL
   BEACH

C. CONCENTRATION
   REVERSE DIGITS (GO TO NEXT STRING LENGTH IF CORRECT ON FIRST TRIAL. STOP IF INCORRECT ON BOTH TRIALS. 1 POINT FOR EACH STRING LENGTH)
   6 9 7 4 2 3 ................. 0 1
   3 8 5 9 6 8 4 3 ................. 0 1
   5 4 2 8 6 1 5 8 6 4 ................. 0 1
   2 7 5 3 9 4 7 3 6 1 9 8 ................. 0 1
   MONTHS IN REVERSE ORDER (1 POINT FOR ENTIRE SEQUENCE CORRECT)
   DEC - NOV - OCT - SEP - AUG - JUL
   JUN - MAY - APR - MAR - FEB - JAN ................. 0 1

D. DELAYED RECALL (1 POINT EACH)
   CHAIR .................................................. 0 1
   BLUE .................................................. 0 1
   ORANGE .............................................. 0 1
   PENCIL .............................................. 0 1
   BEACH .................................................. 0 1

TOTAL POINT SCORE

If boxer applicant scores less than 18 points on the mental status examination, further neurological work-up is indicated unless the score can be explained on the basis of education and/or a language barrier (please note explanation on page 6 of 6)
### DIAGNOSTIC EVALUATION

<table>
<thead>
<tr>
<th>Brain Scan</th>
<th>Electrocardiogram</th>
<th>Eye Exam</th>
<th>HIV</th>
<th>HBSAG</th>
<th>HCAB</th>
</tr>
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**DATE**

**RESULTS**

**Physician's Certification** — I hereby certify that I have examined *(print full legal and ring name of applicant)*

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on this day, *(insert date)*______________, and have found that:

___ **There are no abnormalities** on this applicant’s physical examination that contraindicate participation in boxing.

___ **There are abnormalities** on this applicant’s physical examination that contraindicate participation in boxing *(specify)*:

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**Name of Physician (PRINT):** _____________________________

**Signature of Physician:** X

**Office Address:** _____________________________

**Office Telephone Number:** _____________________________