



Northern California
 USA Boxing, Inc.
BOXING PHYSICAL FORM

Name	Address	D.O.B.	Age
City	State	Zip Code	Phone

HISTORY
HAS APPLICANT EVER HAD ANY OF THE FOLLOWING:

SWOLLEN JOINTS	YES ___	NO ___	RHEUMATISM	YES ___	NO ___
FREQUENT HEADACHES	YES ___	NO ___	CHRONIC COUGH	YES ___	NO ___
SPITTING UP BLOOD	YES ___	NO ___	CONVULSIONS	YES ___	NO ___
SHORTNESS OF BREATH	YES ___	NO ___	FAINING SPELLS	YES ___	NO ___
VENEREAL DISEASE	YES ___	NO ___	DIZZY SPELLS	YES ___	NO ___
WORN OR WEAR GLASSES/CONTACT LENSES	YES ___	NO ___	BLURRING VISION	YES ___	NO ___
DIABETIC	YES ___	NO ___	EPILEPSY	YES ___	NO ___
DEBILITATING DISEASE	YES ___	NO ___	ORAL SURGERY	YES ___	NO ___

Explain any "YES" answers: _____

HAS APPLICANT EVER BEEN KNOCKED UNCONSCIOUS IN ANY SPORT: YES ___ NO ___

IF "YES," LONGEST DURATION OF UNCONSCIOUSNESS: _____

ALSO PLEASE GIVE DATE AND PARTICULARS: _____

MILITARY SERVICE

MILITARY SERVICE: YES ___ NO ___ TYPE OF DISCHARGE: _____

IF REJECTED, PLEASE GIVE REASON: _____

IF MEDICAL DISCHARGE, PLEASE GIVE REASON: _____

ANY HISTORY OF MENTAL ILLNESS? YES ___ NO ___

IF YES, EXPLAIN IN FULL: _____

ALLERGIC REACTIONS TO ANY MEDICATION: YES ___ NO ___

EXPLAIN: _____

TAKING MEDICATION REGULARLY? YES ___ NO ___

EXPLAIN: _____