



CALIFORNIA BORDER ASSOCIATION

LBC #44

424 North 31st Street  
San Diego, CA 90103

Boxing Physical

Name:	D.O.B.	Age:	Telephone:
Address:	City:	State:	Zip:

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 of blood:  Yes  No
- Shortness of breath:  Yes  No
- Convulsions (fits):  Yes  No
- Fainting spells:  Yes  No
- Venereal Disease:  Yes  No
- Worn or wear glasses:  Yes  No
- Blurring of vision:  Yes  No
- Dizzy spells:  Yes  No

- Diabetic / Epilapsy  Yes  No
- And Debilitating disease  Yes  No
- Oral surgery  Yes  No

Explain any yes answers: \_\_\_\_\_

Any knockouts received  Yes  No

Date of last K.O.: \_\_\_\_\_

Longest duration of unconsciousness. \_\_\_\_\_

Was applicant ever knocked unconcious in other sports or in any other way:  Yes  No

If so, give particulars. \_\_\_\_\_

Military Service:

- Military Service:  Yes  No
- If rejected, give reason. \_\_\_\_\_
- Medical discharge:  Yes  No
- If yes, gice reason. \_\_\_\_\_
- Type of discharge if not medical \_\_\_\_\_

- Has applicant ever beeb a patient in a mental hospital:  Yes  No
- If so, explain fully. \_\_\_\_\_

Examination:

- General appearance
- Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Temp. \_\_\_\_\_ Age \_\_\_\_\_
- Disabling scars \_\_\_\_\_
- Pulse (at rest) \_\_\_\_\_ Blood pressure (at rest) \_\_\_\_\_
- Eyes: Vision without glasses
- Right \_\_\_\_\_ Left \_\_\_\_\_
- Pupils equal:  Yes  No
- React to light  Yes  No
- Mouth \_\_\_\_\_ Teeth \_\_\_\_\_ Tonsils \_\_\_\_\_ Neck \_\_\_\_\_
- Enlarge glands:  Yes  No
- Goiter  Yes  No
- Heart: Pulse rhythm  Regular  Irregular
- Apical impluse  Heaving  Normal
- Enlargeent  Yes  No
- Murmurs  Yes  No
- Lungs:
- Hales  Yes  No

- Abdomen -
- Enlargeent of liver  Yes  No
- Enlargeent of spleen  Yes  No
- Hernia -  Femoral  Inguinal  Ventral
- Genitalia - Discharge  Yes  No
- Variococela  Yes  No
- Hands - Evidence of recent injury, fracture.
- Swellings: \_\_\_\_\_
- Unrelated wounds: \_\_\_\_\_
- Reflexes -
- Pupils: \_\_\_\_\_ Knee jerks: \_\_\_\_\_
- Humborg: \_\_\_\_\_ Hadinski \_\_\_\_\_
- Skin -  Rash  Boils
- Any other \_\_\_\_\_

REMARKS: \_\_\_\_\_

I have this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_, examined the above named subject and find him in Satisfactory/Unsatisfactory physical condition to be certified as an amateur boxer.

I certify (or declare), under penalty of purjury, that the foregoing history is true and correct: further. I realize that any misstatement in said history will result in revocation or rejection of ABF card.

Physicians Signature \_\_\_\_\_

Address \_\_\_\_\_

City or Town \_\_\_\_\_

Signature of Applicant \_\_\_\_\_

Name of Person to notify in case of emergency:

Relationship:

Telephone #: