

If yes, give name(s), frequency and dose _____

Have you ever suffered from blurred vision? Yes No

Have you ever had surgical procedures done to eye(s) or the tissue around the eye other than simple sutures of the skin?

Yes No If yes, please explain: _____

Have you ever experienced eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, or dislocated lens? Yes No

If yes, please explain: _____

Boxing and MMA Applicants Only:

Number of knockouts received _____ Date of last KO _____

Longest duration of unconsciousness _____

Length of time before resuming boxing after last knockout _____

Have you ever been knocked unconscious for any reason other than boxing or MMA competition? YES NO

If yes, explain _____

Amateur record: _____ Win _____ Losses _____ Draw

Professional record: _____ Win _____ Losses _____ Draw

Have you ever had Rheumatic Fever? If yes, when were you discharged as cured? _____

List any previous "elimination" matches or "tough-man" events you have fought in: _____

Results _____

List any other serious injuries that you have ever had: _____

Have you ever had a fight stopped for any medical reason? If yes, please specify _____

II. PHYSICAL EXAMINATION

Pages 3 & 4 to be completed by a physician

Height _____ Weight _____ Temperature _____

OTOLOGIC

External Trauma YES NO
Perforated Drum YES NO

NOSE

Instability YES NO
Recent Trauma YES NO
Obstruction YES NO

ORAPHARYNX

Loose Teeth YES NO

ADENOPATHY

YES NO

FACE

Recent Trauma YES NO
Jaw and Temporomandibular Joints Normal Abnormal

LUNGS (Rales)

Normal Abnormal

TESTES

Normal Abnormal

ABDOMEN

Enlargement of Liver YES NO
Hernia YES NO

Enlargement of Spleen YES NO
Femoral Inguinal Ventral

CARDIOVASCULAR

Blood Pressure (supine) _____ (upright) _____
Blood Pressure after 100 hops _____ Blood Pressure 2 minutes later _____
Heart Rate (supine) _____ (after 2 minutes of exercise) _____

ENLARGE GLANDS

YES NO

Goiter

YES NO

HEART

Pulse Rhythm Regular Irregular
Enlargement YES NO

Apical impulse Heavy Normal
Murmurs YES NO

BREAST

(Women Contestants) Mass YES NO

Tenderness YES NO

GYNECOLOGICAL EXAMINATION

(Women Contestants): Normal Abnormal

MUSCULOSKELETAL:

Hands Normal Abnormal
Wrists Normal Abnormal
Elbows Normal Abnormal
Shoulder Girdle Normal Abnormal
Lower Extremities Normal Abnormal

Comments

NEUROLOGIC:

Mental Status Orientation _____/3
5-Minute recall _____/3

Cranial Nerves Normal Abnormal
Strength Normal Abnormal
Tone Normal Abnormal
Gait Normal Abnormal

Coordination:

Finger to Nose Normal Abnormal
Tandem Gait Normal Abnormal

Reflexes:

Pupils: _____ Knee jerk: _____ Romberg: _____ Babinski: _____

Skin:

Rash: _____ Boils: _____ Any other unhealed wounds: _____

Eye Examination: Vision without correction: Right: _____ Left: _____ Vision with correction: Right: _____ Left: _____

Visual fields: Right: _____ Left: _____

Does the applicant have any current or chronic illnesses, physical injuries, abnormalities or physical limitations?

YES NO

If yes, would these interfere in any manner with this person's ability to participate unarmed combat?

YES NO

If yes, what limitations should be placed on this person? _____

COMMENTS OF EXAMINING PHYSICIAN _____ (Please check if the person is or is not medically cleared below)

I hereby certify that I have examined the named individual and in my opinion,

this individual **is** or **is not** medically fit to participate as a contestant in a contact sport,

I also attest that I do not have a professional relationship with, nor financial interest in the earnings of this individual.

(PRINT NAME OF EXAMINING PHYSICIAN – MD or DO)

(PHYSICIAN'S LICENSE NUMBER)

(SIGNATURE OF EXAMINING PHYSICIAN)

(ADDRESS OF PHYSICIAN)

(TELEPHONE NUMBER OF PHYSICIAN)

(Office Stamp or Business Card)

Physicals submitted without the above box checked by the attending physician will be returned for completion and will delay licensure.