



History and Physical Examination Record for a Combative Sport Professional

SECTION 1 — TO BE COMPLETED BY COMBATIVE SPORT PROFESSIONAL

Personal History	THIS IS MY (CHECK ONLY ONE BOX): <input type="checkbox"/> First Application <input type="checkbox"/> Renewal Application		TODAY'S DATE
1. LEGAL NAME		2. RING NAME	
3. STREET ADDRESS (HOME)		TELEPHONE #	EMAIL ADDRESS
CITY		STATE	ZIP CODE + 4
4. DATE OF BIRTH	5. COUNTRY OF BIRTH		Are you a U.S. citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO
6. MANAGER'S NAME		7. TRAINER'S NAME <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
8. CIRCLE THE HIGHEST YEAR OF SCHOOLING YOU HAVE COMPLETED			
ELEMENTARY 1 2 3 4 5 6 7 8		HIGH SCHOOL 9 10 11 12	
COLLEGE 1 2 3 4		OTHER: _____	

Fighting History	9. PRESENT WEIGHT DIVISION		10. NUMBER OF YEARS YOU HAVE BEEN FIGHTING		AMATEUR	PROFESSIONAL	11. YOUR AGE AT FIRST FIGHT	
12. PROFESSIONAL FIGHTING RECORD		WON	LOST	DRAW	13. NUMBER OF AMATEUR FIGHTS		14. DATE OF LAST BOUT	OUTCOME
15. Have you ever been knocked out or suffered a TKO during a match? <input type="checkbox"/> YES* <input type="checkbox"/> NO								
*If YES, explain: _____								
16. Have you ever been suspended medically after a match? <input type="checkbox"/> YES* <input type="checkbox"/> NO								
*If YES, explain: _____								
17. Have you ever been hospitalized after a match? <input type="checkbox"/> YES* <input type="checkbox"/> NO								
*If YES, explain: _____								
18. How many rounds do you spar/full contact during one week? _____								
19. In which states are you licensed to fight professionally? _____								
20. How many weeks in advance do you prepare for a bout? _____								
21. How much weight do you lose in preparation for a bout? _____								
22. How many days prior to a match do you stop sparring/full contact sparring?..... _____								
23. Do you use a sauna to lose weight? <input type="checkbox"/> YES <input type="checkbox"/> NO								
24. Do you use diuretics or water pills prior to a bout to lose weight? <input type="checkbox"/> YES <input type="checkbox"/> NO								
25. Primary gym name, address and telephone #: _____								

Medical History	26. Have you ever been unconscious for any reason? <input type="checkbox"/> YES* <input type="checkbox"/> NO							
*If YES, explain: _____								
27. Do you have any skin problems? <input type="checkbox"/> YES <input type="checkbox"/> NO								
28. Do you bruise easily (get black and blue marks)? <input type="checkbox"/> YES <input type="checkbox"/> NO								
29. Have you ever been treated for alcohol or drug abuse? <input type="checkbox"/> YES <input type="checkbox"/> NO								
30. Did you ever suffer a nervous breakdown or emotional problems? <input type="checkbox"/> YES <input type="checkbox"/> NO								
31. Do you suffer from headaches, dizziness or memory problems? <input type="checkbox"/> YES <input type="checkbox"/> NO								
32. Have you ever had epilepsy (convulsions, fits or seizures)? <input type="checkbox"/> YES <input type="checkbox"/> NO								
33. Have you ever suffered a sudden loss of vision? <input type="checkbox"/> YES <input type="checkbox"/> NO								

SECTION 1 CONTINUED — TO BE COMPLETED BY COMBATIVE SPORT PROFESSIONAL

- 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? YES* NO

*If YES, explain: _____

- 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 illness or surgery which required hospitalization? YES* NO

*If YES, please provide details of the illness or surgery (such as type of surgery or illness, dates of hospitalization, etc.) _____

- 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* — which has not been covered by the above questions? YES NO
- 56. Have you taken any medications, supplements or drugs during the past 30 days? YES* NO

*If Yes, please list: _____

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.

Applicant Print Name

X _____
Applicant Signature

Date

X _____
Physician Print Name

X _____
Physician Signature

Date

Physician License Number: _____ *State and County of Licensee* _____

Reviewed by (Physician)

Date

SECTION 2 — PHYSICAL EXAMINATION — TO BE COMPLETED BY EXAMINING PHYSICIAN

1. VITAL SIGNS

A) BLOOD PRESSURE

B) PULSE (AT REST)

C) PULSE (AFTER 20 HOPS)

D) PULSE (2 MINUTES AFTER EXERCISE)

COMMENT

2. HEAD AND FACE (Describe scars, swelling, tenderness, etc.)

NORMAL ABNORMAL NOT EXAMINED

3. EYES

A) RETINA

NORMAL ABNORMAL NOT EXAMINED

B) CORNEA AND CONJUNCTIVEA

NORMAL ABNORMAL NOT EXAMINED

C) VISUAL ACUITY (SNELLEN CHART)

UNCORRECTED: RIGHT LEFT

CORRECTED: RIGHT LEFT

D) SACCADES

HORIZONTAL
VERTICAL

NORMAL ABNORMAL NOT EXAMINED
 NORMAL ABNORMAL NOT EXAMINED

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

NORMAL ABNORMAL NOT EXAMINED

5. NOSE

NORMAL ABNORMAL NOT EXAMINED

6. OROPHARYNX

NORMAL ABNORMAL NOT EXAMINED

7. NECK

NORMAL ABNORMAL NOT EXAMINED

8. LUNGS

NORMAL ABNORMAL NOT EXAMINED

9. THORAX/CHEST

NORMAL ABNORMAL NOT EXAMINED

10. HEART

NORMAL ABNORMAL NOT EXAMINED

11. ABDOMEN and INGUINAL AREA

NORMAL ABNORMAL NOT EXAMINED

SECTION 2 CONTINUED — TO BE COMPLETED BY EXAMINING PHYSICIAN

12. **BACK and SPINE** NORMAL ABNORMAL NOT EXAMINED

13. EXTREMITIES/MUSCULOSKELETAL SYSTEM

- | | | | | | |
|--------------|-------------------------------|--------------------------------|---------------------------------|-----------------------------------|---------------------------------------|
| A) SHOULDERS | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | <input type="checkbox"/> NOT EXAMINED |
| B) ELBOWS | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | <input type="checkbox"/> NOT EXAMINED |
| C) KNEES | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | <input type="checkbox"/> NOT EXAMINED |
| D) ANKLES | <input type="checkbox"/> LEFT | <input type="checkbox"/> RIGHT | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | <input type="checkbox"/> NOT EXAMINED |
-

14. **SKIN** NORMAL ABNORMAL NOT EXAMINED

15. **LYMPHATIC SYSTEM** NORMAL ABNORMAL NOT EXAMINED

16. NERVOUS SYSTEM — CRANIAL NERVES

- | | | | |
|--|---------------------------------|-----------------------------------|---------------------------------------|
| A) VISUAL FIELD | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | <input type="checkbox"/> NOT EXAMINED |
| B) PUPILLARY REACTION (also NOTE ANY PTOSIS) | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | <input type="checkbox"/> NOT EXAMINED |
| C) EXTRAOCULAR MOVEMENTS (also NOTE NYSTAGMUS) | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | <input type="checkbox"/> NOT EXAMINED |
| D) FACIAL SYMMETRY | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | <input type="checkbox"/> NOT EXAMINED |
| E) GAG REFLEX and TONGUE | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | <input type="checkbox"/> NOT EXAMINED |
-
-
-

17. **MOTOR FUNCTION** NORMAL ABNORMAL NOT EXAMINED

18. **COORDINATION (Finger to Nose, Heel to Knee — rapid successive movements)** NORMAL ABNORMAL NOT EXAMINED

19. **GAIT/ROMBERG** NORMAL ABNORMAL NOT EXAMINED

20. **REFLEXES** NORMAL ABNORMAL NOT EXAMINED

21. MENTAL STATUS

A. Orientation (1pt. for each correct)

What month is it?	0	1
What is today's date?	0	1
What day of the week is it?	0	1
What year is it?	0	1
What time is it right now? (within 1 hr.)	0	1

Orientation score ____ of 5

B. Immediate Memory (1pt. for each correct)

List	Trial 1	Trial 2	Trial 3	Alternative Words		
Elbow	Y N	Y N	Y N	candle	baby	finger
Apple	Y N	Y N	Y N	paper	monkey	penny
Carpet	Y N	Y N	Y N	sugar	perfume	blanket
Saddle	Y N	Y N	Y N	table	sunset	lemon
Bubble	Y N	Y N	Y N	wagon	iron	insect

(Circle all words used. The athlete should repeat words in order. Complete all 3 trials regardless of score on trial 1 & 2. Do not inform the athlete that delayed recall will be tested. Total score equals sum across all 3 trials).

Immediate memory score ____ of 15

C. Concentration

Digits Backwards (1 pt. possible for each string length)

4-9-3	Y N
3-8-1-4	Y N
6-2-9-7-1	Y N
7-1-8-4-6-2	Y N

Alternative digit list

6-2-9	5-2-6	4-1-5
3-2-7-9	1-7-9-5	4-9-6-8
1-5-2-8-6	3-8-5-2-7	6-1-8-4-3
5-3-9-1-4-8	8-3-1-9-6-4	7-2-4-8-5-6

Months in Reverse Order {1 pt. for entire sequence correct}

Dec-Nov-Oct-Sept-Aug-Jul-Jun-May-Apr-Mar-Feb-Jan	Y	N
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Concentration score ____ of 5

D. Delayed Recall

Ask athlete to recall the list of words read earlier in any order.

Elbow	candle	baby	finger
Apple	paper	monkey	penny
Carpet	sugar	perfume	blanket
Saddle	table	sunset	lemon
Bubble	wagon	iron	insect

Delayed recall score ____ of 5

TOTAL POINT SCORE ____ / 30

If applicant scores **less than 22 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)

SECTION 2 CONTINUED — TO BE COMPLETED BY EXAMINING PHYSICIAN

21. MENTAL STATUS, continued . . .

Explanation of score less than 22 points:

DIAGNOSTIC EVALUATION

	Brain Scan	EKG	Hematology	Eye Exam	HIV	HBSAG	HCAB
DATE							
RESULT							

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

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

_____ **There are no abnormalities** on this applicant’s physical examination that contraindicate participation in combat sports or mixed martial arts.

_____ **There are abnormalities** on this applicant’s physical examination that contraindicate participation in combat sports or mixed martial arts (*specify*):

Name of Physician (*PRINT*): _____

Signature of Physician: **X** _____

Office Address: _____

Office Telephone Number: _____