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Department of State
State Athletic Commission
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NEW YORK STATE OF OPPORTUNITY.

New York State Athletic Commission

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

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): ❑ First Application ❑ 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? ❑ YES ❑ NO

6. MANAGER'S NAME

7. TRAINER'S NAME ❑ MALE ❑ 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? . . . . . ❑ YES* ❑ NO

*If YES, explain: _____

16. Have you ever been suspended medically after a match? . . . . . ❑ YES* ❑ NO

*If YES, explain: _____

17. Have you ever been hospitalized after a match? . . . . . ❑ YES* ❑ 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? . . . . . ❑ YES ❑ NO

24. Do you use diuretics or water pills prior to a bout to lose weight? . . . . . ❑ YES ❑ NO

25. Primary gym name, address and telephone #: _____

Medical History

26. Have you ever been unconscious for any reason? . . . . . ❑ YES* ❑ NO

*If YES, explain: _____

27. Do you have any skin problems? . . . . . ❑ YES ❑ NO

28. Do you bruise easily (get black and blue marks)? . . . . . ❑ YES ❑ NO

29. Have you ever been treated for alcohol or drug abuse? . . . . . ❑ YES ❑ NO

30. Did you ever suffer a nervous breakdown or emotional problems? . . . . . ❑ YES ❑ NO

31. Do you suffer from headaches, dizziness or memory problems? . . . . . ❑ YES ❑ NO

32. Have you ever had epilepsy (convulsions, fits or seizures)? . . . . . ❑ YES ❑ NO

33. Have you ever suffered a sudden loss of vision? . . . . . ❑ YES ❑ 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 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*** — 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)

	RIGHT	LEFT	RIGHT	LEFT
UNCORRECTED:			CORRECTED:	

D) SACCADES

HORIZONTAL ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

VERTICAL ❑ 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	❑ LEFT	❑ RIGHT	❑ NORMAL	❑ ABNORMAL	❑ NOT EXAMINED
B) ELBOWS	❑ LEFT	❑ RIGHT	❑ NORMAL	❑ ABNORMAL	❑ NOT EXAMINED
C) KNEES	❑ LEFT	❑ RIGHT	❑ NORMAL	❑ ABNORMAL	❑ NOT EXAMINED
D) ANKLES	❑ LEFT	❑ RIGHT	❑ NORMAL	❑ ABNORMAL	❑ NOT EXAMINED

14. SKIN ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

15. LYMPHATIC SYSTEM ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

16. NERVOUS SYSTEM — CRANIAL NERVES

A)	VISUAL FIELD	❑ NORMAL	❑ ABNORMAL	❑ NOT EXAMINED
B)	PUPILLARY REACTION (also NOTE ANY PTOSIS)	❑ NORMAL	❑ ABNORMAL	❑ NOT EXAMINED
C)	EXTRAOCULAR MOVEMENTS (also NOTE NYSTAGMUS)	❑ NORMAL	❑ ABNORMAL	❑ NOT EXAMINED
D)	FACIAL SYMMETRY	❑ NORMAL	❑ ABNORMAL	❑ NOT EXAMINED
E)	GAG REFLEX and TONGUE	❑ NORMAL	❑ ABNORMAL	❑ 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

SECTION 2 CONTINUED — TO BE COMPLETED BY EXAMINING PHYSICIAN

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)		Alternative digit list		
4-9-3	Y N	6-2-9	5-2-6	4-1-5
3-8-1-4	Y N	3-2-7-9	1-7-9-5	4-9-6-8
6-2-9-7-1	Y N	1-5-2-8-6	3-8-5-2-7	6-1-8-4-3
7-1-8-4-6-2	Y N	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

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: _____