



**History and Physical Examination Record for a Combative Sport Professional**

**SECTION 1 — TO BE COMPLETED BY COMBATIVE SPORT PROFESSIONAL**

|  |   |   |  |
|--|---|---|--|
| <b>Personal History</b>                                    | THIS IS MY (CHECK ONLY ONE BOX):<br><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: _____  |  |

|  |                            |     |  |      |                              |              |                             |         |
|--|----------------------------|-----|--|------|------------------------------|--------------|-----------------------------|---------|
| <b>Fighting History</b>  | 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 #: _____   |                            |     |  |      |                              |              |                             |         |

|   |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|
| <b>Medical History</b>  | 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 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)*  
DOS-0759 (Rev. 08/16)

\_\_\_\_\_  
*Date*

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

|                       |                    |                          |                                     |
|-----------------------|--------------------|--------------------------|-------------------------------------|
| <b>1. VITAL SIGNS</b> |                    |                          |                                     |
| 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                        |              | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | <input type="checkbox"/> NOT EXAMINED |
| B) CORNEA AND CONJUNCTIVEA       |              | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | <input type="checkbox"/> NOT EXAMINED |
| C) VISUAL ACUITY (SNELLEN CHART) | <u>RIGHT</u> |                                 | <u>RIGHT</u>                      | <u>LEFT</u>                           |
|                                  | UNCORRECTED: |                                 | CORRECTED:                        |                                       |

**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**  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

\_\_\_\_\_

**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

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)

Explanation of score less than 22 points:

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**DIAGNOSTIC EVALUATION**

|        | Brain Scan | EKG | CBC/PT-<br>INR/PTT | 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*)

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

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

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

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Name of Physician (*PRINT*): \_\_\_\_\_

Signature of Physician: **X** \_\_\_\_\_

Office Address: \_\_\_\_\_

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Office Telephone Number: \_\_\_\_\_