



AMATEUR ATHLETE PHYSICAL EXAMINATION

*Only a licensed physician may conduct this examination and complete this form.
 Please complete this form in its entirety.*

BOXING

KICKBOXING/MUAY THAI

Last Name	First Name	Middle Name
Address:		
Street (No PO BOX)	City	State
		Zip Code
Telephone number:	Email:	
Male / Female (check one)	Date of Birth: (MM / DD / YYYY):	
PHYSICAL HISTORY: Please check all that applies below: Asthma Blood in urine Allergies		
Fainting spells	Rupture (hernia)	Chest pains
	Operations	Shortness of breath
		Swollen joints
Rheumatism	Diabetes	Frequent headaches
	Convulsions (fits)	Chronic cough
		Spitting of blood
Cerebral hemorrhage or serious head injury If yes, please explain: _____		
When was the last time you took any type of medication or drug? (State what type and when and be specific): _____ _____		
Have you ever undergone any type of surgery? Yes No (State what type and when and be specific): _____		
When was the last time you took any type of vitamin supplement? (State what type and when and be specific): _____ _____		
Amateur Boxing Record:		Amateur Mixed Martial Arts record:
Wins: _____ Wins by KO/TKO/Submissions: _____		Wins: _____ Wins by KO/TKO/Submissions: _____
Losses: _____ Losses by KO/TKO/Submissions: _____		Losses: _____ Losses by KO/TKO/Submissions: _____

AMATEURATHLETE PHYSICAL EXAMINATION

APPLICANT NAME: _____

PHYSICAL EXAMINATION:

General appearance: _____ Height: _____ Weight: _____
Temperature: _____ Disabling scars: _____ Mouth: _____ Teeth: _____ Tonsils: _____
Neck: _____ Pulse at rest: _____ Pulse after 100 hops: _____
Blood pressure at rest: _____ After 100 hops: _____ 2 minutes later: _____
Enlarged glands: **Yes No** Goiter: **Yes No** Heart: Pulse rhythm (circle one) **Regular Irregular**
Murmurs: **Yes No** Musculoskeletal system: _____
Apical impulse (circle one): **Heavy Normal** Enlargement: **Yes No** Lungs: Rales **Yes No**
Abdomen: Enlargement of liver **Yes No** Breasts: Mass **Yes No** Tenderness **Yes No**
Discharge **Yes No** Enlargement of Spleen: **Yes No** Hernia: **Yes No**
Testicles: Normal **Yes No**
Remarks: _____

Reflexes: Pupils _____ Knee jerks _____ Romberg _____ Babinski _____
Skin: Tone _____ Rash _____ Boils _____ Other: _____
Unhealed wounds: _____
Remarks: _____

EYE HISTORY:

Have you ever had blurred vision? **Yes No** If yes, please explain in full: _____

Have you ever had any surgical procedures done to your eye(s) or the tissues around your eye(s) other than simple sutures of the skin around the eye? **Yes No** If yes, please explain in full: _____

Have you ever been diagnosed by a physician to have significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, or dislocated lens? **Yes No** If yes, please explain in full: _____

EYE EXAMINATION:

Vision without glasses Right _____ Left _____
Vision with glasses Right _____ Left _____
Visual fields Right _____ Left _____

EXAMINING PHYSICIAN:

Based on your personal observation and review of the test results and considering Commission rules, is it your medical opinion that this applicant is physically fit to be licensed and compete in combative sports? **Yes No** If no, please explain: _____

LICENSED PHYSICIAN'S NAME (print) _____	MEDICAL LICENSE NO. _____	APPLICANT NAME (print) _____
ADDRESS/CITY/STATE/ZIP CODE _____		APPLICANT SIGNATURE _____
TELEPHONE NO. _____	DATE/TIME _____	PERSON WHO ASSISTED'S NAME (print) _____
PHYSICIAN'S SIGNATURE _____		PERSON WHO ASSISTED'S SIGNATURE _____

Office Use
Approved by: _____
Date: _____
Exp. Date: _____