



## California State Athletic Commission

1424 Howe Ave. Ste. #33  
 Sacramento, CA 95825  
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 (916) 263-2195 FAX (916) 263-2197

**PROFESSIONAL ATHLETE PHYSICAL EXAMINATION**

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

**BOXING****MIXED MARTIAL ARTS****KICKBOXING**

**Office Use**  
 Approved by: \_\_\_\_\_  
 Date: \_\_\_\_\_

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

Revised December 2007

# PROFESSIONAL ATHLETE 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 Regular Irregular –  
Murmurs: Yes No – Musculoskeletal system: \_\_\_\_\_  
Apical impulse: 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 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: \_\_\_\_\_

**You must also go to an Ophthalmologist and undergo a  
Commission ATHLETE OPHTHALMOLOGIC EXAMINATION**

## 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

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