PHYSICAL EXAMINATION FORM

Name:_____ DOB:_____/_____/_____ Date of Exam:____/_____/_____

Fighter Complaints:

_____

_____

_____

_____

_____

_____

Visual Acuity: OD _____ OS _____ OU _____ Audiometry dbl: 20( ) 25 ( ) 40 ( )

(With glasses/contacts) OD _____ OS _____ OU _____

Near Vision: OD _____ OS _____ OU _____

Hz 500 1000 2000 4000

Height: _____ Weight: _____ Weight Class: _____

UA: S.G. _____ Protein _____ Blood _____ Glucose _____ Nitrite _____ Leuk _____ Billi _____

Medications: 1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

7) _____ 8) _____ 9) _____

SYSTEM REVIEW: (check if abnormal)

Constitutional:	Skin:	Head/Eyes:	Ears/Nose/Throat/Neck:
☐ Fevers	Rash	Change in Vision	Difficulty Hearing
Swollen Nodes			
☐ Chills	Moles ☐	Hair loss	Ringing in Ears ☐
Stiffness			
☐ Sweats	☐Flushing ☐	Puritis	Congestion
Sinus Pain			
☐ Excessive Thirst	☐Dry Skin		Gun/Teeth Problems
☐ Fatigue/Change in Energy	☐Lesions		Swallowing Difficulties
	☐Bruising		Hay Fever/Allergies
	☐Lumps		

Heart:
□ Palpitations
□ Chest Pains
□ Rapid Rate
Weight Loss
□ Fainting
□ Edema

Lungs:
□Shortness of Breath
□Wheezing
□Cough
□Exertional Dyspnea
□Orthopnea

Chest Wall:
□ Pain
□ Lumps
□ Nipple Discharge
□ Rib Strain

GI:
□ Abdominal Pain □ Hemorrhoids
□ Change in Appetite □ N/V
□ Constipation □
□ Diarrhea □ Weight Gain
□ Change in Bowel Habits GERD
□ Blood in Stool □ Dysphasia

GU:
□ Frequent Urination
□ Nighttime Urination
□ Leakage
□ Burning/Urgency
□ Discharge
□ Sexual Dysfunction

Bone/Joint:
□Muscle Pains
□Cramps
□Spasms
□Restless Leg
□Weakness
□Back Pain

CNS/Psych:
□ Headache □ Anxiety □ Swelling □
□ Dizziness □ Insomnia □ Fungus □
□ Memory Loss □ Tremor □ Varicosities □
□ Numbness □ Vertigo □
□ Change in Coordination
□ Depression

Extremity:

Other: (list)

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Name:_____

PHYSICAL EXAMINATION FORM

Vital Signs: B/P _____/_____ PULSE _____ RESP. _____
TEMP _____

HEENT:	nl./neg.	Abn.	Comments:
PERL/EOMI	□	□	_____
TM	□	□	_____
Turbinates	□	□	_____
Throat	□	□	_____
Nodes	□	□	_____
Bruits	□	□	_____
Thyroid	□	□	_____
JVD	□	□	_____
Axillary Nodes	□	□	_____
Nystagmus	□	□	_____

Lungs:
CTA □ □ _____

Heart:
Rate □ □ _____
Rhythm □ _____
M/G/R □ □ _____
Ectopy □ □ _____

Back:	nl/neg.	Abn.	Comments:
Curvature	□	□	
CVA Tenderness	□		

Chest/Breast:
Masses □ □
Dimpling □ □
Discharge □ □
Deferred □

Genitalia:
External □ □
Testicular Mass □
Hernia □ □
Lesions □ □
Rectal □ □
Deferred □

Pelvic:
Masses □ □

Lesions ☐ ☐

Abdomen: Ovaries: ☐ ☐

Soft ☐ ☐ _____ Cervix ☐ ☐

NT ☐ ☐ _____ Deferred/NA

ND ☐ ☐ _____

Masses ☐ ☐ _____ Ext./Mus/Skel:

Organomegaly ☐ _____ C/C/E ☐ ☐

Hernia ☐ ☐ _____ Onychomycosis ☐

Weight ☐ ☐ _____ Varicose Veins ☐☐

Pulses ☐ ☐

Skin: Joints ☐ ☐

Lesions/Herpes ☐ _____ Muscles ☐ ☐

Rash ☐ ☐ _____

Alopecia ☐ ☐ _____ Neuro: ☐ ☐

Scars/Tatoos ☐ ☐ _____ Appearance ☐ ☐

Tests: (Complete if Results Available)

EKG: ☐ ☐ Date: _____ CT Brain ☐

Date:_____

HIV: ☐ ☐ Date: _____ MRI Brain ☐

Date:_____

HepBsAg ☐ ☐ Date: _____

HepC Ab ☐ ☐ Date _____

Comments:

_____

_____

_____

The above fighter is: _____ is NOT: _____ medically cleared to participate
(Must be signed by an MD/DO)

Physician Name (Print): _____, MD/DO

Signature:_____

Address:_____

_____

City: _____ State: _____ Zip: _____ Date of Examination:_____

Name: _____ Federal ID #: _____

Address: _____ Date of Birth: _____/_____/_____

City:_____ _____ State: _____ Country: _____

Telephone #: ( ) _____ E-mail:_____

Professional Fight Record: W _____ L _____ D _____ Date of Last Fight: _____/_____/_____

If you answer **yes** to any of the following questions, please explain in the space provided below.

1) Do you have any medical problems? Yes ( ) No ( )

2) Do you take any medications on a regular basis? Yes ( ) No ( )

3) Have you taken any medications for any purpose over the past 2 weeks? Yes ( ) No ( )

4) Have you ever been stopped or knocked out? Yes ( ) No ( ) *If **yes**, please list date:* _____/_____/_____

5) Did anyone in your immediate family die from a heart problem before age 40? Yes ( ) No ( )

6) Do you have any injuries which may affect your ability to fight? Yes ( ) No ( )

7) Did you injure yourself while training for this fight? Yes ( ) No ( )

8) Do you wear protective equipment while fighting? (for example-a knee brace) Yes ( ) No ( )

9) Have you ever had surgery? (including eye or musculoskeletal) Yes ( ) No ( )

10) Are you taking any vitamins, sport supplements, or herbal medications? Yes ( ) No ( )

11) Do you ever have any of the following?

a)Frequent Headaches?	Yes	( )	No	( )
b)Dizziness or Fainting?	Yes	( )	No	( )
c)Seizures?	Yes	( )	No	( )
d)Chest Pains?	Yes	( )	No	( )
e)Shortness of Breath?	Yes	( )	No	( )
f) Heart Murmur?	Yes	( )	No	( )
g)Asthma?	Yes	( )	No	( )

12) How much weight did you lose leading up to this fight? _____

Please explain all **yes** answers in space below:

I have answered the above questions truthfully and to the best of my knowledge. I know that purposely providing misinformation can result in disciplinary action, loss of my Federal ID #, and fines or suspensions.

Boxer Signature: _____**Witness**: _____
Date:_____/_____/_____