PHYSICIAN'S PRE-BOUT EXAM
BOXING/MIXED MARTIAL ARTS

Legal Name:_____
Date:_____
Last First Middle

Federal/National ID#:_____ Annual Medical & Eye Exam Complete: Y N

Temp:_____ □ Afebrile RR:_____ BP:_____/_____ HR:_____ SaO2: _____%

	Normal	Abnl		Normal	Abnl		Normal	Abnl
Head/Periorbital/CN's	□	□	Heart (Rhythm/sounds)	□	□	Alertness/Orientation	□	□
PERRLA/EOMI/Vision	□	□	Lungs/Ribs	□	□	Tandem Gait	□	□
Jaw/Oropharynx/Teeth	□	□	Abdomen	□	□	Romberg/Pronator Drift	□	□
Nose (stability/obstruction)	□	□	Upper Extremities	□	□	Finger to Nose	□	□
Ears/Hearing (grossly)	□	□	Lower Extremities	□	□	Motor	□	□
Neck	□	□	Skin (Rashes, infxns)	□	□	Other:_____		

(Women only) Pregnancy: □ Yes □ No

Abnormalities:_____
I hereby certify that based on the statements made by the participant to me and on the Medical History form, and my physical findings, it is my opinion that said participant □ **IS** □ **IS NOT** in good physical condition and able to compete in professional boxing/mixed martial arts.

Reason not cleared for competition: _____

_____ _____ _____
Physician's Name, M.D. Signature License No. Date

Don

PHYSICIAN'S POST-BOUT EVALUATION

□ Won □ Lost □ KO □ TKO □ Decision □ Draw □ DQ □ NC □ LOC □ Choke □Submission Suspension:_____

Time of initial evaluation:_____ Fighter stable: □ Yes □ No

(No entry indicates grossly normal findings.)

	Normal	Abnl		Normal	Abnl		Normal	Abnl
Head/Periorbital	□	□	Extremities(fractures)	□	□	Alertness/Orientation	□	□
Nose (stability/epistaxis)	□	□	Skin (Lacerations)	□	□	HR	_____	
Neck	□	□	Neuro (Grossly)	□	□	SaO2	_____%	
Chest (Grossly)	□	□	Other:_____					

Abnormalities:_____

Mechanism of Injury/Diagnoses:_____

Advised to report for second evaluation in 30 minutes: □ Yes □ No □ Athlete failed to report for second evaluation

Results/time of second evaluation:_____

Recommended Medical Attention:
□ Immediate evaluation in an Emergency Department – Sent to ED at:_____

□ Other:_____

□ Boxer refuses advice of physician

Comments:_____

_____ _____ _____
Physician's Name, M.D. Signature License No. Date

I Certify that I have given the Ring Doctor true and accurate information. I understand that boxing/MMA is a potentially dangerous sport that can result in injuries, including but not limited to brain damage, paralysis, and death. I also agree to allow the doctor to treat me for injuries that occur during the event.

Fighter's signature:_____ date _____

Certified Ringside Physician

PHYSICIAN'S LICENSING EXAM: BOXING/MMA/KICKBOXING

Legal Name: _____
Last First Middle

Address: _____
Street City State Country

Date of Birth: ____/____/____ Sex: □ M □ F Federal/National ID#: _____

PHYSICAL EXAM: This section is to be completed by the examining physician.

Height: _____ Weight: _____ Temp: _____ □ Afebrile RR: _____ BP: _____/_____ HR: _____

		Normal	Abnormal
General		□	□
HEENT	Head	□	□
	PERRLA/EOMI	□	□
	Periorbital Regions	□	□
	Ears/Hearing (grossly)	□	□
	Jaw/Oropharynx/Teeth	□	□
	Nose (stability, obstruction)	□	□
	Lymph Nodes	□	□
	Neck	□	□
Vision	PERRLA/EOMI	□	□
	Peripheral/Fields (grossly)	□	□
Heart	Rhythm/Sounds/Murmurs	□	□
Chest	Lungs	□	□
	Ribs	□	□

		Normal	Abnormal
Abd.	(Hernias)	□	□
	(Masses/Tenderness)	□	□
Ext.	Extremities	□	□
	Hands/Wrists	□	□
	Knuckle Push-ups	□	□
	Duck/Crab walk	□	□
Skin	(Rashes/Lacerations)	□	□
Neuro.	Alertness/Orientation	□	□
	Cranial Nerves (grossly)	□	□
	Tandem Gait	□	□
	Romberg/Pronator Drift	□	□
	Finger to Nose	□	□
	Reflexes	□	□
	Other: _____	□	□

Abnormalities: _____

MEDICAL TESTING:	**Negative/ Normal**	**Positive**	**Not Reviewed**	**Not Required**	**Date of test/exam**
Hepatitis B Surface Antigen	□	□	□	□	____/____/____
Hepatitis C Antibody	□	□	□	□	____/____/____
HIV Antibody or Quantitative RNA (circle)	□	□	□	□	____/____/____
CT Scan/MRI Brain (circle)	□	□	□	□	____/____/____
EKG	□	□	□	□	____/____/____
Ophthalmologic Examination	□	□	□	□	____/____/____
Neurological Examination	□	□	□	□	____/____/____
Women: HCG Urine/Serum (circle)	□	□	□	□	____/____/____
Other: _____	□	□	□	□	____/____/____

I hereby certify that based on the statements made by the participant on the reverse side of this form, my physical findings, and pending any medical testing not yet reviewed, it is my opinion that said participant is in good physical condition and

□ **IS** □ **IS NOT** medically cleared to be licensed as a competitor in professional boxing/MMA.

Reason if not cleared for competition: _____

_____ _____ _____ _____
Physician's Name, M.D./D.O. Signature License No. Date

_____ _____
email Phone

MEDICAL HISTORY FORM
BOXING/MIXED MARTIAL ARTS

Legal Name:_____ Federal/National ID#:_____
Last First Middle

Address:_____
Street City State Country

Telephone:_____ E-mail:_____ Date of Birth:_____/_____/_____

Sex: □ M □ F Emergency Contact:_____ Emergency Telephone:_____

This section is to be completed by the athlete.

Health History

Do you have or have you ever had any of the following?

	Yes	No		Yes	No
Seizure	□	□	High blood pressure	□	□
Headaches	□	□	Asthma or wheezing	□	□
Cerebral hemorrhage	□	□	Broken bones or sprains	□	□
Passed out during exercise	□	□	Neck or spine injury	□	□
Double or blurred vision	□	□	Hernia	□	□
Lasik, PRK, or other eye surgery	□	□	Cold sores, fever blisters or herpes	□	□
Retinal Detachment	□	□	Diabetes	□	□
Hearing difficulty	□	□	Bleeding problems	□	□
Broken nose	□	□	Hepatitis	□	□
Chest pain	□	□	Heat stroke/heat exhaustion	□	□
Irregular heart beat or murmur	□	□	Recent illness or fever	□	□

	Yes	No
Have you ever had a concussion, a head injury, or lost consciousness?	□	□
Are you currently using or have you ever used anabolic steroids?	□	□
Have you ever had any other surgeries?	□	□
Do any diseases run in your family?	□	□
Have you seen a doctor for *any* medical problem in the last 3 months?	□	□
Do you have any other medical conditions?	□	□
Women only: Have you ever had any type of breast surgery?	□	□
Is there any chance you may be pregnant?	□	□

If "Yes" to any of the above, explain: _____

Are you allergic to any medications or supplements? _____

What medications or supplements are you taking on a regular basis? _____

What medications or supplements have you taken within the last two weeks? _____

Sport History

Amateur Record:_____ Pro Record:_____

Date of last bout: Result: Number of times knocked out:

Number of times knocked out in past year:_____ Date of last knock out:_____

I hereby authorize the Athletic Commission to have immediate and unlimited access to any and all medical records which may relate to my fitness to participate in boxing/mixed martial arts or are related to an injury or suspected injury sustained as a result of a boxing/mixed martial arts match. I certify that I have been training faithfully and am in good physical condition. I attest that the answers given above are true and correct to the best of my knowledge and belief. I understand that the examining physician depends on the reliability of the statements I made above and I am not withholding any information from the examining physician. 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.

_____ _____ _____