

ARIZONA STATE BOXING AND MIXED MARTIAL ARTS COMMISSION

PHYSICAL EXAM PHYSICAL EXAMINATION FOR PROFESSIONAL BOXER/UNARMED COMBATANT

Applicant Phone: (____)____-_____

APPLICANT INFORMATION

MALE FEMALE

Applicant
Last Name _____ First Name _____ Middle _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip _____

PHYSICAL HISTORY

Has applicant had any of the following conditions:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Rupture (hernia) | <input type="checkbox"/> Chest pain | <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 head aches | <input type="checkbox"/> Convulsions (fits) | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> Spitting blood | <input type="checkbox"/> Cerebral hemorrhage or any other serious injury | | |

Number of knockouts received _____ Date of last knockout _____

Longest duration of unconsciousness _____

Have you ever been knocked unconscious in any other sport or in any other way? Yes No

If yes, explain: _____

BOXING/UNARMED COMBAT RECORD

Pro Boxing	Wins _____	Losses _____	Draws _____
Pro MMA	Wins _____	Losses _____	Draws _____
Amateur MMA	Wins _____	Losses _____	Draws _____

PHYSICAL EXAMINATION

General appearance _____ Height _____ Weight _____ Temperature _____

Disabling scars _____ Mouth _____ Teeth _____ Tonsils _____ Neck _____

Pulse at rest _____ Blood pressure at rest _____

Pulse after 100 hops _____ Blood pressure after 100 hops _____

Blood pressure 2 minutes later _____

Enlarged glands Yes No Goiter Yes No

Heart: Pulse rhythm Regular Irregular Apical impulse Heavy Normal

Enlargement Yes No Murmurs Yes No

Lungs: Rales Yes No

Breasts: Mass Yes No Tenderness Yes No Discharge Yes No

Abdomen: Enlargement of liver Yes No Enlargement of spleen Yes No

Hernia Yes No Enlargement of spleen Yes No

Testicles: Normal Yes No Remarks: _____

Pelvic: Normal Yes No Remarks: _____

Reflexes: Pupils _____ Knee jerks _____ Romberg _____ Babinski _____

Skin: Rash _____ Boils _____ Any other unhealed wounds: _____

Speech: Slurred? Yes No Other: _____

General issues (memory, judgment): _____

Remarks: _____

EYE HISTORY

Has applicant every had any of the following conditions:

1. Blurred vision? Yes No
2. Surgical procedures done to his/her eye(s) or the tissues around the eye other than simple sutures of the skin around the eye?
 Yes No
3. Has applicant ever been informed by a physician that he/she had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia lens? Yes No

EYE EXAMINATION

Vision without glasses	
Left	Right

Vision with glasses	
Left	Right

Visual Field	
Left	Right

SEROLOGY

THE ORIGINAL REQUIRED LAB REPORT WITH APPLICANT'S NAME AND DATE THE TEST WAS PERFORMED MUST BE SUBMITTED.

REQUIRED LAB REPORTS TO INCLUDE: HIV, Hepatitis B (Surface Antigen) and Hepatitis C (Antibody)

EXAMINING PHYSICIAN (MUST BE AN MD OR DO PHYSICIAN)

I have examined the above named subject and I HAVE HAVE NOT medically cleared to fight.

Remarks: _____

PHYSICIAN'S NAME / LICENSE # (PLEASE PRINT) SIGNATURE BY (MD or DO) ONLY DATE

STREET ADDRESS

CITY STATE ZIP CODE PHONE NUMBER

MEDICAL RELEASE AUTHORIZATION

APPLICANT:

I AUTHORIZE any physician to release to the Arizona State Boxing Commission any of my medical records in his/her possession. I also authorize the Arizona State Boxing Commission to release any medical information or other personal information with respect to my status and licensure as a professional boxer or unarmed combatant which may be contained in any of its records to other State Commissions.

I agree that a photographic copy of this authorization shall be valid as the original.

I agree that this authorization will be valid for a period of one year from the date indicated in this document.

NAME OF APPLICANT (PLEASE PRINT) APPLICANT'S SIGNATURE DATE