Association of Boxing Commissions and Combative Sports

Physical Examination Form

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

Fighter Complaints: ____

____

____

Visual Acuity: OD _______ OS _______ OU _______

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

Near Vision: OD _______ OS _______ OU _______

Audiometry dbl: 20( ) 25 ( ) 40 ( )

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:
- ☐ Fevers
- ☐ Chills
- ☐ Sweats
- ☐ Excessive Thirst
- ☐ Fatigue/Change in Energy

Skin:
- ☐ Rash
- ☐ Moles
- ☐ Flushing
- ☐ Dry Skin
- ☐ Lesions
- ☐ Bruising
- ☐ Lumps

Head/Eyes:
- ☐ Change in Vision
- ☐ Hair loss
- ☐ Puritis

Ears/Nose/Throat/Neck:
- ☐ Difficulty Hearing
- ☐ Ringing in Ears
- ☐ Congestion
- ☐ Gun/Teeth Problems
- ☐ Swallowing Difficulties
- ☐ Hay Fever/Allergies
- ☐ Swollen Nodes
- ☐ Stiffness
- ☐ Sinus Pain

Heart:
- ☐ Palpitations
- ☐ Chest Pains
- ☐ Rapid Rate
- ☐ Fainting
- ☐ Edema

Lungs:
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Cough
- ☐ Exertional Dyspnea
- ☐ Orthopnea

Chest Wall:
- ☐ Pain
- ☐ Lumps
- ☐ Nipple Discharge
- ☐ Rib Strain

GI:
- ☐ Abdominal Pain
- ☐ Change in Appetite
- ☐ Constipation
- ☐ Diarrhea
- ☐ Change in Bowel Habits
- ☐ Blood in Stool
- ☐ Hemorrhoids
- ☐ N/V
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ GERD
- ☐ 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
- ☐ Dizziness
- ☐ Memory Loss
- ☐ Numbness
- ☐ Change in Coordination
- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia
- ☐ Tremor
- ☐ Vertigo

Extremity:
- ☐ Swelling
- ☐ Fungus
- ☐ Varicosities

Other: (list)
- ☐
- ☐
- ☐
- ☐

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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	☐	☐	____________________
Abdomen:			
Soft	☐	☐	____________________
NT	☐	☐	____________________
ND	☐	☐	____________________
Masses	☐	☐	____________________
Organomegaly	☐	☐	____________________
Hernia	☐	☐	____________________
Weight	☐	☐	____________________
Skin:			
Lesions/Herpes	☐	☐	____________________
Rash	☐	☐	____________________
Alopecia	☐	☐	____________________
Scars/Tatoos	☐	☐	____________________

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	☐	☐	____________________
Ovaries:	☐	☐	____________________
Cervix	☐	☐	____________________
Deferred/NA	☐		____________________
Ext./Mus/Skel:			
C/C/E	☐	☐	____________________
Onychomycosis	☐	☐	____________________
Varicose Veins	☐	☐	____________________
Pulses	☐	☐	____________________
Joints	☐	☐	____________________
Muscles	☐	☐	____________________
Neuro:	☐	☐	____________________
Appearance	☐	☐	____________________

Tests: (Complete if Results Available)

Test			Date
EKG:	☐	☐	Date: ____________________
HIV:	☐	☐	Date: ____________________
HepBsAg	☐	☐	Date: ____________________
HepC Ab	☐	☐	Date ____________________
CT Brain	☐	☐	Date: ________________
MRI Brain	☐	☐	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: ________________________

Association of Boxing Commissions and Combative Sports

Medical History Form

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.

Fighter Signature: ____________________**Witness**: ________________________**Date**:______/______/______

Forms Courtesy of :
Dr. Michael Schwartz
Co-Chairman – Medical Advisory Committee