



STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
ANNUAL PHYSICAL EXAMINATION

OFFICE OF ATHLETICS
 PO BOX 1335
 JEFFERSON CITY, MO 65102
 (573) 751-0243
 FAX (573) 751-5649

NAME (LAST, FIRST, MIDDLE)		DATE OF EXAM	
RING NAME		SOCIAL SECURITY NO.	
CURRENT ADDRESS			
TELEPHONE NUMBER	DATE OF BIRTH	AGE	SEX

MEDICAL HISTORY (PLEASE COMPLETE AS THOROUGHLY AS POSSIBLE)

A. HAS APPLICANT EVER HAD ANY OF THE FOLLOWING CONDITIONS, PLACE AN "X" IF IT APPLIES TO YOU

<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 Headaches	<input type="checkbox"/> Convulsions (fits)	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Spitting of Blood	<input type="checkbox"/> Cerebral Hemorrhage or any other serious head injury		

1. HAVE YOU EVER BEEN HOSPITALIZED?
 Yes No If "yes", give nature of problem(s), date(s), location(s) and attending physicians:

2. HAVE YOU EVER HAD EYE SURGERY?
 Yes No If "yes", explain:

3. HAVE YOU EVER HAD A RETINAL DETACHMENT?
 Yes No If "yes", explain:

4. DO YOU REGULARLY OR OCCASIONALLY TAKE ANY MEDICATIONS?
 Yes No If "yes", give name(s), frequency and dose:

5. HAVE YOU PREVIOUSLY BEEN INJURED IN A BOXING/KICKBOXING/MARTIAL, WRESTLING ARTS EVENT?
 Yes No If "yes", describe injuries:

6. LONGEST DURATION OF UNCONSCIOUSNESS

7. WHAT IS YOUR RECORD?
 Wins _____ Losses _____ Draws _____

8. WHAT IS YOUR RECORD FOR THE LAST YEAR?
 Wins _____ Losses _____ Draws _____ Number of times lost by TKO or KO _____

9. WHEN WERE YOU LAST GIVEN A MEDICAL SUSPENSION FROM A COMMISSION? (DATE)

10. WHY WERE YOU SUSPENDED?

11. (WOMEN CONTESTANTS ONLY) DATE OF LAST MENSTRUAL PERIOD

PHYSICAL EXAM

HEIGHT	WEIGHT	TEMPERATURE
OTOLOGIC External Trauma <input type="checkbox"/> Yes <input type="checkbox"/> No Perforated Drum <input type="checkbox"/> Yes <input type="checkbox"/> No		NOSE Instability <input type="checkbox"/> Yes <input type="checkbox"/> No Recent Trauma <input type="checkbox"/> Yes <input type="checkbox"/> No Obstruction <input type="checkbox"/> Yes <input type="checkbox"/> No
OROPHARYNX Loose Teeth <input type="checkbox"/> Yes <input type="checkbox"/> No		ADENOPATHY <input type="checkbox"/> Yes <input type="checkbox"/> No
FACE Recent Trauma <input type="checkbox"/> Yes <input type="checkbox"/> No Jaw and Temporomandibular Joints <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		TESTES <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
LUNGS (RALES) <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		

PHYSICAL EXAM (CONTINUED)

ABDOMEN			ENLARGED GLANDS		GOITER
Enlargement of Liver	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Enlargement of Spleen	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Femoral	<input type="checkbox"/> Inguinal	<input type="checkbox"/> Ventral

CARDIOVASCULAR

Blood Pressure (supine) _____ (upright) _____

Blood Pressure after 100 hops _____ Blood Pressure 2 minutes later _____

Heart Rate (supine) _____ (after 2 minutes of exercise) _____

HEART

Pulse Rhythm	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Apical Impulse	<input type="checkbox"/> Heavy <input type="checkbox"/> Normal
Enlargement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Murmurs	<input type="checkbox"/> Yes <input type="checkbox"/> No

BREAST (WOMEN CONTESTANTS)

Mass	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tenderness	<input type="checkbox"/> Yes <input type="checkbox"/> No
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GYNECOLOGICAL EXAMINATION (WOMEN CONTESTANTS)

Normal Abnormal

MUSCULOSKELETAL

Hands	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Comments:	_____
Wrists	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Comments:	_____
Elbows	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Comments:	_____
Shoulder Girdle	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Comments:	_____
Lower Extremities	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Comments:	_____

NEUROLOGIC

Mental Status

Orientation _____ /3

5-minute recall _____ /3

Cranial Nerves	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Strength	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Tone	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Gait	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Coordination:			
Finger to Nose	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Tandem Gait	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

COMMENTS OF EXAMINING PHYSICIAN

I hereby certify that I have examined the named individual and in my opinion, this **individual** **is** or **is not** medically fit to participate as a contestant in a professional boxing, kick boxing, martial arts contest or wrestling. I also attest that I do not have a professional relationship with, nor financial interest in the earnings of this individual.

PRINT NAME OF EXAMINING PHYSICIAN	PHYSICIAN'S LICENSE NUMBER
SIGNATURE OF EXAMINING PHYSICIAN	ADDRESS OF PHYSICIAN
	TELEPHONE NUMBER OF PHYSICIAN

MEDICAL RELEASE OF INFORMATION

I hereby authorize the Office of Athletics to release, disclose, and furnish to any other boxing or athletic commission affiliated with the Association of Boxing Commissions, (ABC), any and all of my medical records concerning my licensure as a participant including, but not limited to, all required medical examinations, laboratory test results for the HIV, hepatitis virus and drug screening, hospital records, and any other information regarding conditions related to the propriety of my licensure as a participant (including history, findings, diagnosis, or prognosis).

I understand, and it is agreed, that the signing of this Medical Information Release is optional, and that my declining to sign this document will not result in any adverse action being taken against me by the Office of Athletics based on my decision. I understand, and it is agreed, that the medical records described herein will not be released for any purpose other than for a member commission affiliated with the ABC to determine my eligibility to participate in a professional boxing, kick boxing, martial arts or wrestling match. I understand, and it is agreed, that this authorization shall remain in effect until June 30, of each even numbered year and is relevant to all medical records described herein, whether such record were created prior to, or subsequent to, the date the authorization is signed.

By signing below, I hereby authorize the release of my medical information.

PRINT NAME	SIGNATURE OF BOXER	DATE
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