



REPORT OF PHYSICAL EXAMINATION TO BE COMPLETED BY AN M.D., D.O., PA-C, OR NURSE PRACTITIONER

- **HIV: HIV ½ serum Ab (HIV ½ SERUM antibodies, EIA, with confirmation, CPT Code 86703)**
- **Hepatitis B: HBsAg (Hepatitis B SURFACE ANTIGEN, CPT Code 87340)**
- **Hepatitis C: HCab (Hepatitis C ANTIBODY, CPT Code 86803)**

Name:	Other Names Used:		
Home Address:	City:	State:	Zip:
Date of Birth:	Age:	Biological Male	Biological Female

EXAMINATION

Height:	Weight:	Temperature:	Pulse:	Blood Pressure:
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MEDICAL

	Normal	Abnormal Findings
Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span>height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Nose/Throat		
Eyes		
Ears		
Lymph Nodes		
Heart (Dynamic maneuvers for any murmur)		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional (e.g., duck-walk, single-leg hop, knuckle pushups)		

Examining Physician's Comments:

I, _____, have examined the above named subject and reviewed the complete **Medical History** submitted by the competitor and find the athlete does not present apparent clinical contraindications to practice and participate in the sport(s) outlined below. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete. In my opinion, the athlete is to be in: Satisfactory Unsatisfactory condition to be licensed as a Boxer/MMA/Kickboxer Fighter/Referee.

Date of Exam: _____

Medical Personnel's Name, (MD, DO, NP, PA-C)

Medical Personnels' Signature

Address

Date

City, State, Zip

Phone Number

I hereby declare, under penalty of perjury, that the forgoing history is true and correct. Further, I realize that any misrepresentation in said medical history may result in disciplinary action.

Signature of Applicant

Date Signed



Oregon State Athletic Commission
500 Airport Rd SE
Salem, OR 97301
Phone: 503-871-5091 Fax: 503-540-1440
MEDICAL HISTORY



This form is to be filled out by the competitor prior to seeing the physician.

Name:	Date of Birth:	Age:
Male <input type="checkbox"/> Female <input type="checkbox"/>	Sport(s): Mixed Martial Arts <input type="checkbox"/> Boxing <input type="checkbox"/> Kickboxing <input type="checkbox"/> Muay Thai <input type="checkbox"/>	
Medicines and Allergies: Please list all of the prescription and over-the-counter medications and supplements (herbal and nutritional) that you are currently taking:		
<hr/>		
<hr/>		
<hr/>		

Do you have any allergies?	Yes <input type="checkbox"/> (if yes, please specify below)	No <input type="checkbox"/>
<input type="checkbox"/> Medicines:	<input type="checkbox"/> Pollens:	<input type="checkbox"/> Food: <input type="checkbox"/> Stinging Insects:
Please answer all questions below to the best of your knowledge. If you do not know the answer to a question, CIRCLE that question. Please explain any "YES" answers at the bottom of the page.		

GENERAL QUESTIONS			
1. Has a doctor ever denied or restricted your participation in sports for any reason?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
2. Do you have any medical conditions? If so, please identify below: Ashtma Anemia Diabetes Infections Other:	YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. Have you ever spent the night in the hospital?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
4. Have you ever had surgery?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
HEART HEALTH QUESTIONS			
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
7. Does your heart ever race or skip beats (irregular beats) during exercise?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
8. Have a doctor ever told you that you have any heart problems? If so, check all that apply: High Blood Pressure A heart murmur High Cholesterol A heart infection Kawasaki Disease Other:	YES <input type="checkbox"/> NO <input type="checkbox"/>		
9. Has a doctor ever ordered a test for your heart? (For example, ECG, EKG, echocardiogram)?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
10. Do you get lightheaded or feel more short of breath than expected during exercise?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
11. Have you ever had an unexplained seizure?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
12. Do you get more tired or short of breath more quickly than your peers during exercise?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY			
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. Does anyone in your family have hypertonic cardiomyopathy, Marfan syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
16. Has anyone in your family had unexplained fainting, unexplained seizures or near drowning?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
BONE AND JOINT QUESTIONS			
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
18. Have you ever had any broken or fractured bones or dislocated joints?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
19. Have you ever had an injury that required x-rays, MRI, CT Scan, injections, therapy, a brace, a cast, or crutches?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
20. Have you ever had a stress fracture?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21. Have you ever been told that you have or have you had an x-ray for neck instability or Atlantoaxial instability? (Down syndrome or dwarfism)	YES <input type="checkbox"/> NO <input type="checkbox"/>		
22. Do you regularly use a brace, orthotics, or other assistive devices?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
23. Do you have a bone, muscle, or joint injury that bothers you?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
24. Do any of your joints become painful, swollen, feel warm, or look red?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
25. Do you have any history of juvenile arthritis or connective tissue disease?	YES <input type="checkbox"/> NO <input type="checkbox"/>		

MEDICAL QUESTIONS			
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
27. Have you ever used an inhaler or taken an asthma medication?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
28. Is there anyone in your family who has asthma?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
29. Were you born without or are you missing a kidney, an eye, a testicle (male), your spleen or any other organ?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
30. Do you have groin pain or a painful bulge or hernia in the groin area?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
31. Have you had an infectious mononucleosis (mono) within the last month?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
32. Do you have any rashes, pressure sores, or other skin problems?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
33. Have you had a herpes or MRSA skin infection?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
34. Have you ever had a head injury or concussion?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headaches or memory problems?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
36. Do you have a history of seizure disorder?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
37. Do you have headaches with exercise?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
39. Have you ever been unable to move your arms or legs after being hit or falling?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	
40. Have you ever become ill while exercising in heat?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
41. Do you get frequent muscle cramps when exercising?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
42. Do you or someone in your family have sickle cell trait or disease?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
43. Have you had any problems with your eyes or vision?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
44. Have you had any eye injuries?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
45. Do you wear glasses or contact lenses?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
46. Do you wear protective eyewear, such as goggles or a face shield?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
47. Do you worry about your weight?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
48. Are you trying to or has anyone recommended that you gain or lose weight?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
49. Are you on a special diet or do you avoid certain types of foods?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
50. Have you ever had an eating disorder?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
51. Do you have any concerns that you would like to discuss with a doctor?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
FEMALES ONLY			
52. Have you ever had a menstrual period?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
53. How old were you when you had your first menstrual period?	AGE:		
54. How many periods have you had in the last 12 months?			
55. Have you ever been pregnant?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
EXPLAIN "YES" ANSWERS HERE:			

I hearby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete: _____ Date: _____