OREGON STATE POLICE
Oregon State Athletic Commission
3565 Trelstad Ave SE
Salem OR 97317
TELEPHONE: 503-378-8739 FAX: 503.378.2360
OSAC@osp.oregon.gov

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

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

EXAMINATION

Height:	Weight:	Temperature:	Pulse:	Blood Pressure:

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
3565 Trelstead
Salem, OR 97317
Phone: 503-871-5091 Fax: 503-378-2360

MEDICAL HISTORY

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

Name:	Date of Birth:	Age:
Male ☐ Female ☐	Sport(s): Mixed Martial Arts ☐ Boxing ☐ Kickboxing ☐ Muay Thai ☐	

Medicines and Allergies: Please list all of the prescription and over-the-counter medications and supplements (herbal and nutritional) that you are currently taking:_____

_____

_____

_____

Do you have any allergies?	Yes ☐ (if yes, please specify below)	No ☐	
☐ Medicines:	☐ Pollens:	☐ Food:	☐ 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 ☐	NO ☐
2. Do you have any medical conditions? If so, please identify below:	YES ☐	NO ☐
Ashtma Anemia Diabetes Infections Other:		
3. Have you ever spent the night in the hospital?	YES ☐	NO ☐
4. Have you ever had surgery?	YES ☐	NO ☐
HEART HEALTH QUESTIONS		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	YES ☐	NO ☐
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	YES ☐	NO ☐
7. Does your heart ever race or skip beats (irregular beats) during exercise?	YES ☐	NO ☐
8. Have a doctor ever told you that you have any heart problems? If so, check all that apply:	YES ☐	NO ☐
High Blood Pressure A heart murmur High Cholesterol A heart infection Kawasaki Disease Other:		
9. Has a doctor ever ordered a test for your heart? (For example, ECG, EKG, echocardiogram)?	YES ☐	NO ☐
10. Do you get lightheaded or feel more short of breath than expected during exercise?	YES ☐	NO ☐
11. Have you ever had an unexplained seizure?	YES ☐	NO ☐
12. Do you get more tired or short of breath more quickly than your peers during exercise?	YES ☐	NO ☐
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 ☐	NO ☐
14. Does anyone in your family have hypertonic cardiomyopathy, Marfan syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?	YES ☐	NO ☐
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	YES ☐	NO ☐
16. Has anyone in your family had unexplained fainting, unexplained seizures or near drowning?	YES ☐	NO ☐
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 ☐	NO ☐
18. Have you ever had any broken or fractured bones or dislocated joints?	YES ☐	NO ☐
19. Have you ever had an injury that required x-rays, MRI, CT Scan, injections, therapy, a brace, a cast, or crutches?	YES ☐	NO ☐
20. Have you ever had a stress fracture?	YES ☐	NO ☐
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 ☐	NO ☐
22. Do you regularly use a brace, orthotics, or other assistive devices?	YES ☐	NO ☐
23. Do you have a bone, muscle, or joint injury that bothers you?	YES ☐	NO ☐
24. Do any of your joints become painful, swollen, feel warm, or look red?	YES ☐	NO ☐
25. Do you have any history of juvenile arthritis or connective tissue disease?	YES ☐	NO ☐

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