**ATHLETE PHYISCAL EXAMANIATION**

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| --- |
| **ATHLETE PERSONAL INFORMATION**  |
|  |  | **[ ]**  | **MALE** | **[ ]**  | **FEMALE** |  |  |  |
| **Athlete Name:** |  |  |  |
|  | (Last Name) |  | (Middle Name) |  | (Last Name) |
| **Athlete Address:** |  |
|  | (Number and Street Name)  |  | (City) | (State) | (Zip Code) |  |
| **Cell Number:** |  | **Work Number:** |  |
|  | (Area code) |  |  |  |  |  | (Area code)  |  |
| **PHYSICAL HISTORY**  |
| Has the athlete experienced any of the following conditions:  |
|  | [ ]  | Bleeding Disorder | [ ]  | Rapture (hernia)  | [ ]  | Chest Pain  | [ ]  | Operations  |
|  |  |  |  |  |  |  |  |  |
|  | [ ]  | Shortness of Breath  | [ ]  | Swollen joints  | [ ]  | Rheumatism | [ ]  | Diabetes |
|  |  |  |  |  |  |  |  |  |
|  | [ ]  | Frequent headaches | [ ]  | Convulsions (fits) | [ ]  | Chronic cough | [ ]  | Fainting Spells  |
|  |  |  |  |  |  |  |  |  |
|  | [ ]  | Spitting blood  | [ ]  | Cerebral hemorrhage or any other serious injury  |
|  |
| Number of knockouts athletes received:  |  | Date of last knockout: | **/** **/**  |
|  |  |  |  |
| Longest duration of unconsciousness: |       |
|  |  |
| Has the athlete ever been knocked unconscious during a competition or by result of any physical activity?  |
|  | [ ]  | Yes  | [ ]  | No  | If yes, explain:  |       |
| **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: |       | BP after 2 min: |       |
|  |
| Enlarged glands: | [ ]  | Yes | [ ]  | No |  Goiter:  |  [ ]  | Yes  | [ ]  | No  |
| Heart: | Pulse rhythm: | [ ]  | Regular | [ ]  | Irregular |  | Apical Pulse: | [ ]  | 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  |
|  |
| Pelvic: | Normal: | [ ]  | Yes | [ ]  | No  | Remarks:  |       |
|  |
| Testicles:  | Normal:  | [ ]  | Yes  | [ ]   | No  | Remarks:  |       |
|  |
| Reflexes:  | Pupils:  |       | Knee jerks: |       | Romberg:  |       | Babinski: |       |
|  |
| Skin: | Rash:  |       | Boils:  |       | Any other unhealed wounds: |       |
|  |
| Speech: | Slurred: | [ ]  | Yes  | [ ]  | No  |  | General Issues (memory/judgement): |       |

**PHYSICAL EXAMINATION 2ND PAGE PRINT ATHLETE NAME:**

|  |
| --- |
| **ATHLETE COMBATE RECORD**  |
|  | Professional Boxing:  | Wins: |       | Losses:  |       | Draws: |       |  |
|  |  |  |  |  |  |  |  |
|  | Professional MMA: | Wins:  |       | Losses: |       | Draws: |       |  |
|  |
|  | Amateur MMA:  | Wins:  |       | Losses:  |       | Draws:  |       |  |
| **ATHLETE EYE HISTORY** |
| Has athlete ever experienced any of the following conditions: |
|  | 1. 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 | If yes, explain:  |       |
|  |  |
|  | 1. Has athlete 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 | If yes, explain:  |       |
|  |
|  | 1. Blurred vision?
 | [ ]  | Yes | [ ]  | No | If yes, explain: |       |
| **ATHLETE EYE EXAMINATION**  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Vision Without glasses |  | Vision With glasses |  | Visual Field |
| Left | Right |  | Left | Right |  | Left | Right |
|  |  |  |  |  |  |  |  |

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| **SEROLOGY**  |
| **THE ORGINAL REQUIRED LAB REPORT WITH ATHLETE’S NAME AND DATE THE TEST WAS PROFORMED MUST BE SUBMITTED.** **REQUIRED LAB REPORTS TO INCLUDE: HIV, Hepatitis B (Suface Antigen), Hepatitis C (Anitbody)** |
| **EXAMINING PHYSICIAN (MUST BE AN MD OR DO PHYSICIAN)**  |
| **I have examined the above name subject and I**  | **[ ]**  | **HAVE** | **[ ]**  | **HAVE NOT medically cleared to fight** |
|  |
| Additionally remarks regarding athletes physical health or well-being? |  |
|  |
|       |       |  |       |       |
| PHYSICIAN NAME | LICENSE # (PLEASE PRINT) |  | SIGNATURE BY (MD OR DO) ONLY | DATE |
|  |
|       |       |       |       |
| BUSINESS STREET ADDRESS (NAME & STREET) | CITY | STATE | ZIP CODE |
|  |
|       |  |       |       |
| BUSINESS PHONE NUMBER |  | NAME OF NURSING ASSISTANT  | DATE |
| **MEDICAL RELEASE AUTHORIZATION**  |
| Athlete: **I AUTHORIZE any physician to release to the Pascua Yaqui Athletic Commission any of my medical records in his/her possession. I also authorize the Athletic Commission to release any medical information or other personal information with respect to my status and licensure as a professional athlete or unarmed combatant which may be contacted in any of its records to other State or Tribal Commissions.** **I agree that this authorization will be valid for a period of one year from the date indicated in this document.**  |
|  |  |  |
| Name of Athlete (Please Print) | Athlete Signature | Date  |