STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION

ANNUAL PHYSICAL EXAMINATION

MUST BE COMPLETED AND SIGNED BY M.D. OR D.O.

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

☐ Fainting Spells ☐ Rupture (hernia) ☐ Chest Pain ☐ Operations
☐ Shortness of Breath ☐ Swollen Joints ☐ Rheumatism ☐ Diabetes
☐ Frequent Headaches ☐ Convulsions (fits) ☐ Chronic Cough ☐ Bleeding Disorder
☐ Spitting of Blood ☐ 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:

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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 ☐ Yes ☐ No
Perforated Drum ☐ Yes ☐ No

OROPHARYNX
Loose Teeth ☐ Yes ☐ No

FACE
Recent Trauma ☐ Yes ☐ No
Jaw and Temporomandibular Joints ☐ Normal ☐ Abnormal

LUNGS (RALES)
☐ Normal ☐ Abnormal

NOSE
Instability ☐ Yes ☐ No
Recent Trauma ☐ Yes ☐ No
Obstruction ☐ Yes ☐ No

ADENOPATHY
☐ Yes ☐ No

TESTES
☐ Normal ☐ Abnormal

PHYSICAL EXAM (CONTINUED)

ABDOMEN

Enlargement of Liver	☐ Yes	☐ No
Hernia	☐ Yes	☐ No
Enlargement of Spleen	☐ Yes	☐ No

☐ Femoral ☐ Inguinal ☐ Ventral

ENLARGED GLANDS ☐ Yes ☐ No

GOITER ☐ Yes ☐ No

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	☐ Normal	☐ Abnormal	Apical Impulse	☐ Heavy	☐ Normal
Enlargement	☐ Yes	☐ No	Murmurs	☐ Yes	☐ No

BREAST (WOMEN CONTESTANTS)

Mass	☐ Yes	☐ No	Tenderness	☐ Yes	☐ No

GYNECOLOGICAL EXAMINATION (WOMEN CONTESTANTS)

☐ Normal ☐ Abormal

MUSCULOSKELETAL

Hands	☐ Normal	☐ Abnormal	Comments: ________________________________
Wrists	☐ Normal	☐ Abnormal	Comments: ________________________________
Elbows	☐ Normal	☐ Abnormal	Comments: ________________________________
Shoulder Girdle	☐ Normal	☐ Abnormal	Comments: ________________________________
Lower Extremities	☐ Normal	☐ Abnormal	Comments: ________________________________

NEUROLOGIC

Mental Status — Orientation ______________/3

5-minute recall ______________/3

Cranial Nerves	☐ Normal	☐ Abnormal	Strength	☐ Normal	☐ Abnormal
Tone	☐ Normal	☐ Abnormal	Gait	☐ Normal	☐ Abnormal
Coordination:					
Finger to Nose	☐ Normal	☐ Abnormal	Tandem Gait	☐ Normal	☐ Abnormal

COMMENTS OF EXAMINING PHYSICIAN

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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.

MUST BE COMPLETED AND SIGNED BY M.D. OR D.O.

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