



**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

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

**PHYSICAL EXAM (CONTINUED)**

<b>ABDOMEN</b>		<b>ENLARGED GLANDS</b>	<b>GOITER</b>
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.

**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
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**REQUIRED MEDICAL TESTS FOR  
NEWLY LICENSED CONTESTANTS**

CONTESTANT PRELICENSE CHECK LIST

**PHYSICAL EXAMINATION**

**ANNUAL PHYSICAL**

(THIS PHYSICAL EXAM SHALL BE OTHER THAN THE PRE-FIGHT PHYSICAL AND MUST BE COMPLETED BY AN MD OR DO, WITHIN **30 DAYS** PRIOR TO APPLICATION FOR LICENSURE.)

**BLOOD TESTS**

(CERTIFIED COPIES OF MEDICAL TESTS PERFORMED BY A CERTIFIED LABORATORY VERIFYING THE APPLICANT IS NOT INFECTED MUST BE SUBMITTED WITH THE APPLICATION FOR LICENSURE)

HIV (HUMAN IMMUNODEFICIENCY VIRUS)

HEPATITIS B\*\*

HEPATITIS C

(BLOOD TESTS SHALL NOT BE MORE THAN **90 DAYS** BEFORE APPLICATION IS SUBMITTED TO THE OFFICE)

**\*\*A CONTESTANT MAY PROVIDE PROOF THAT THEY HAVE RECEIVED THE SERIES OF THREE IMMUNIZATIONS FOR THE HEPATITIS B VIRUS, UPON PROVIDING THIS DOCUMENTATION, CONTESTANTS NO LONGER ARE REQUIRED TO PROVIDE THE NEGATIVE TESTS.**

**Note: IF THE ANTIBODY TEST FOR HEPATITIS B IS POSITIVE, THERE MUST BE A TEST RESULT FOR THE ANIGENT TEST FOR HEPATITIS B AND IT MUST BE NEGATIVE TO OBTAIN A LICENSE.**

**FEDERAL IDENTIFICATION CARD**

BOXING FEDERAL ID CARD

(NEW BOXING CONTESTANS MUST OBTAIN THEIR FEDERAL IDENTIFCATION CARD FROM **THEIR HOME STATE BOXING COMMISSION**)

MIXED MARTIAL ARTS FEDERAL ID CARD

NEW MIXED MARTIAL ARTS CONTESTANS MUST OBTAIN THEIR FEDERAL IDENTIFCATION CARD FROM THEIR HOME STATE BOXING COMMISSION OR THE MISSOURI OFFICE OF ATHELTICS WILL ISSUE THE CARD)