

Professional Combatant Dilated Eye Exam

Only a licensed Ophthalmologist or Optometrist may conduct this examination and complete this form. Please complete this form in its entirety.

Full Name: _____

First Name

Middle Name

Last Name

HISTORY

Has applicant ever had any of the following conditions?

1. Blurred vision? [] Yes [] No
2. 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
3. Has applicant had or been informed by a physician that he/she had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, dislocated lens, or cataract? [] Yes [] No

If yes, please explain: _____

4. Eye Disease? [] Yes [] No

If yes, list nature of diseases: _____

5. Eye Injury? [] Yes [] No

If yes, list nature of injuries: _____

6. Retinal reattachment? [] Yes [] No

If yes, please explain: _____

7. Does the applicant have any other visual condition that would prevent him/her from safely engaging in boxing or martial arts activities? [] Yes [] No

If yes, please explain:

EXAMINATION

Vision: _____
 Without glasses With Glasses

Refraction: If either eye is 20/60 or worse

Right _____ / _____ Right _____ Sph _____ Cyl x _____ Acuity _____
 Left _____ / _____ Left _____ Sph _____ Cyl x _____ Acuity _____

Intraocular Right _____ mmHg Tension Left _____ mmHg
Remarks: _____

_____ Motility Normal _____ Motility Abnormal
_____ Binocular Vision Normal _____ Binocular Vision Abnormal

Slit Lamp Exam:

	Normal	Abnormal	
	Right/ Left	Right/Left	Specify Abnormalities
Conjunctiva _____	/	/	Iris/Pupil _____
Cornea _____	/	/	Lens _____
_____	/	/	_____
_____	/	/	_____
_____	/	/	_____

Indirect ophthalmoscopy with scleral depression (Dilated Pupil):

	Normal	Abnormal	
	Right/Left	Right/Left	Specify Abnormalities
Disc _____	/	/	
Macula _____	/	/	
Lens _____	/	/	
Peripheral Retina _____	/	/	

Examining Physician:

Based on your personal observation and review of the test results and considering Tennessee Athletic Commission rules, is it your medical opinion that this applicant is physically fit to be licensed and compete in combative sports? [] Yes [] No If no, please explain:

Licensed Physician's Name _____

Medical License Number _____

Physician's Signature

Date/ Time