



Professional Combatant Physical Examination

A licensed Nurse Practitioner, Physician Assistant, or Medical Doctor must conduct this examination and complete this form. Please complete this form in its entirety. Participant's Full Name:

First Name	Middle Name	Last Name
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PHYSICAL HISTORY: Please check all that apply:

- ☐ Asthma ☐ Blood in urine ☐ Allergies ☐ Fainting spells ☐ Rupture (hernia)
☐ Chest pains ☐ Operations ☐ Shortness of breath ☐ Swollen joints
☐ Rheumatism ☐ Diabetes ☐ Frequent headaches ☐ Convulsions (fits)
☐ Chronic cough ☐ Spitting of blood ☐ Cerebral hemorrhage or serious head injury
If you checked any box, please explain below:

When was the last time you took any type of medication or drug? (State with specificity what type and when):

Have you ever undergone any type of surgery? ____ Yes ____ No (State with specificity what type and when):

When was the last time you took any type of vitamin supplement? (State with specificity what type and when):

General appearance: _____ Height _____ Weight _____ Temperature _____
_____ Disabling scars _____ Mouth _____ Teeth _____
_____ Tonsils _____ Neck _____
_____ Pulse at rest _____ Pulse after 100 hops _____
_____ Blood pressure at rest _____ Blood pressure after 100 hops _____
_____ Blood pressure two (2) minutes later _____

Enlarged glands: [☐] Yes [☐] No Goiter: [☐] Yes [☐] No

Heart: Pulse rhythm [☐] Regular [☐] Irregular Murmurs: [☐] Yes [☐] No

Musculoskeletal system: _____

Apical impulse: [☐] Heavy [☐] Normal Enlargement: [☐] Yes [☐] No

Lungs: Rales [☐] Yes [☐] No Abdomen: Enlargement of liver [☐] Yes [☐] No

Breasts: Mass [☐] Yes [☐] No [☐] Not Applicable Tenderness [☐] Yes [☐] No

Discharge: [☐] Yes [☐] No Enlargement of Spleen: [☐] Yes [☐] No

Hernia: [☐] Yes [☐] No Testicles: Normal [☐] Yes [☐] No [☐] Not Applicable

Reflexes: Pupils _____ Knee jerks _____ Romberg _____ Babinski _____

Skin: Tone _____ Rash _____ Boils _____ Other _____

Unhealed wounds: _____

Remarks: _____

Examining Physician:

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

Licensed Nurse Practitioner/ Physician Assistant/ Physician's Name _____

Medical License Number _____

Nurse Practitioner/ Physician Assistant/ Physician's Signature Date/ Time