Illinois Department of Financial and Professional Regulation, Athletic Unit
555 W Monroe St., Ste 8S-100, Chicago, IL 60661 ● Ph: (312) 814-2721, Fax: (217) 557-8480

BOXING/FULL CONTACT MARTIAL ARTS
CONTESTANT'S COMPLETE PHYSICAL EXAMINATION FORM

Legal Name:_____ Federal/National ID#:_____
Last First Middle

Address:_____
Street City State Zip Country

Date of Birth:_____/_____/_____ Sex: □ M □ F Social Security #:_____

PHYSICAL EXAM: This section is to be completed by the examining physician.

BP:_____/_____ HR:_____ RR:_____ Temp:_____ □ Afebrile Height:_____ Weight:_____

		Normal	Abnormal
General		□	□
HEENT	Head	□	□
	PERRLA/EOMI	□	□
	Periorbital regions	□	□
	Ears/Hearing (grossly)	□	□
	Jaw/Oropharynx/Teeth	□	□
	Nose (stability, obstruction)	□	□
	Lymph nodes (cervical)	□	□
	Neck	□	□
Vision	Peripheral/Fields (grossly)	□	□
Heart	Rhythm/Sounds/Murmurs	□	□
Chest	Lungs	□	□
	Ribs	□	□

		Normal	Abnormal	Deferred
Abd.	(Masses/Tenderness)	□	□	
	(Hernias)	□	□	□
Ext.	Hands/Wrists	□	□	
	Elbows/Shoulders	□	□	
	Knees/Hips	□	□	
Skin	(Rashes/Lacerations)	□	□	
Neuro	Alertness/Orientation	□	□	
	Cranial nerves (grossly)	□	□	
	Romberg/Pronator drift	□	□	
	Finger to nose	□	□	
	Reflexes (Symmetric)	□	□	
	Gait/Tandem gait	□	□	
	Other:_____	□	□	

Abnormals:_____

MEDICAL TESTING:	**Negative/ Normal**	**Positive**	**Not Reviewed**	**Not Required**	**Date of test/exam**
Hepatitis B Surface Antigen	□	□	□	□	_____/_____/_____
Hepatitis C Antibody	□	□	□	□	_____/_____/_____
HIV 1/2 Serum Antibody	□	□	□	□	_____/_____/_____
CT Scan Brain or MRI Brain (circle)	□	□	□	□	_____/_____/_____
EKG	□	□	□	□	_____/_____/_____
Ophthalmologic Examination (Uncorrected vision must be at least 20/60)	□	□	□	□	_____/_____/_____
Neurological Examination	□	□	□	□	_____/_____/_____
Women: HCG Urine/Serum (circle)	□	□	□	□	_____/_____/_____
Other:_____	□	□	□	□	_____/_____/_____

I hereby certify that based on the statements made by the contestant completing the reverse side of this form, my physical findings, and pending any medical testing not yet reviewed, it is my opinion that said contestant

☐ **IS** ☐ **IS NOT** in good physical condition and is medically cleared to be licensed as a competitor in professional boxing or full contact mixed martial arts.

☐ **The patient presented a valid form of photo identification and I have personally verified his/her identity.**

Reason not cleared for competition:_____

_____ _____ _____ _____
Physician's Name, M.D./D.O. Signature License No. Date

_____ _____ _____
Office Address Phone Fax

Rev. 11/1/22

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BOXING/FULL CONTACT MARTIAL ARTS CONTESTANT'S MEDICAL HISTORY FORM

Legal Name:_____ Federal/National ID#:_____
Last First Middle

Address:_____
Street City State Zip Country

Telephone:_____ E-mail:_____ Date of Birth:____/____/____

Sex: □ M □ F Emergency Contact:_____ Emergency Telephone:_____

HEALTH HISTORY

Do you have now or have you ever had any of the following?

	Yes	No		Yes	No
Seizure, flashing lights	□	□	High blood pressure	□	□
Headaches or dizziness	□	□	Asthma or wheezing	□	□
Cerebral hemorrhage	□	□	Broken bones, sprains or dislocations	□	□
Passed out during exercise	□	□	Neck or spine injury	□	□
Double vision or blurred vision	□	□	Hernia	□	□
LASIK, PRK, or any eye surgery	□	□	Cold sores, fever blisters or herpes	□	□
Eye problems (retinal detachment)	□	□	Diabetes	□	□
Hearing problems	□	□	Bleeding problems	□	□
Broken nose	□	□	Hepatitis or liver problems	□	□
Chest pain	□	□	Heat stroke, heat exhaustion	□	□
Irregular heart beat or murmur	□	□	Recent illness or fever	□	□
Muscle cramping during exercise	□	□	Sickle cell trait or disease	□	□

	Yes	No
Have you ever had a concussion, head injury or lost consciousness (knocked out)?	□	□
Do you or have you ever used anabolic steroids, testosterone, or banned substances?	□	□
Have you ever had any other surgeries?	□	□
Do any diseases run in your family or have any died suddenly before age 50?	□	□
Have you seen a doctor for *any* medical problem in the last 3 months?	□	□
Do you have any training or sparring injuries?	□	□
Do you have any piercings (tongue, earrings, etc.)?	□	□
Women only: Have you ever had any type of breast surgery?	□	□
Is there any chance you may be pregnant?	□	□

If "Yes" to any of the above or you have *any* other medical conditions explain: _____

Are you allergic to any medications or supplements? _____

What medications or supplements are you taking on a regular basis? _____

What medications or supplements have you taken within the last two weeks? _____

SPORT HISTORY

Amateur Record:_____ Pro Record:_____

Date of last bout:_____ Result:_____ Number of times knocked out:_____

Number of times knocked out in past year:_____ Date of last time knocked out:_____

I hereby authorize the Athletic Commission/Unit to have immediate and unlimited access to any and all medical records which may relate to my fitness to participate in boxing/full contact martial arts or are related to an injury or suspected injury sustained as a result of a boxing/ full contact mixed martial arts match. I certify that I have been training faithfully and am in good physical condition. I attest that the answers given above are true and correct to the best of my knowledge and belief. I understand that the examining physician depends on the reliability of the statements I made above and I am not withholding any information from the examining physician. I further understand that all statements and information supplied by me are made under the penalty of perjury and if untrue and not informative will lead to penalty and/or suspension.

_____ _____ _____
Name (printed) Signature Date

The other side of this form is to be completed by the physician.