Kentucky Boxing and Wrestling Commission

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PHYSICAL REPORT

☐**Boxing** ☐**MMA** ☐**Wrestling** ☐**Referee**

Date of Exam: ____________

Name: ____ ____________________
Last First Middle Date of Birth

Address: ________________________________ City: ____________ State: ____ Zip: __________

Phone Number: _____________________ Age: ________ Sex: _______

I. MEDICAL HISTORY (to be completed by applicant)

A. Have you ever suffered from any of the following conditions:

□ Fainting spells	□ Rupture (hernia)	□ Chest pains	□ Operations
□ Shortness of breath	□ Swollen joints	□ Rheumatism	□ Diabetes
□ Frequent headaches	□ Convulsions (fits)	□ Chronic cough	□ Bleeding disorder
□ Migraine headaches	□ Spitting of blood	□ Facial fracture	□ Cerebral hemorrhage or head injury

Do you suffer from any type of headache other than migraine? □ YES □ NO If yes, what type? ____________________

Have you ever had a head or neck injury? □ YES □ NO If yes, explain: ____

____

Have you ever had a seizure? □ YES □ NO If yes, when? ____

Do you have any allergies? □ YES □ NO If yes, what are they? ____

Have you ever been hospitalized? □ YES □ NO If yes, give nature of problems(s), date(s), location(s) and attending physicians. ____

____

Have you suffered a concussion? _______ If yes, how many? _________ Date of last concussion ___________________

Have you previously been injured in a sporting event? □ YES □ NO If yes, Describe injuries: __________________

____

Do you regularly or occasionally take any medications, drugs, or drops? □ YES □ NO

If yes, give name(s), frequency and dose ____

____

Have you ever suffered from blurred vision? ☐Yes ☐No

Have you ever had surgical procedures done to eye(s) or the tissue around the eye other than simple sutures of the skin?
☐Yes ☐No If yes, please explain: ____

Have you ever experienced eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, or dislocated lens? ☐Yes ☐No
If yes, please explain: ____

Boxing and MMA Applicants Only:

Number of knockouts received _______________ Date of last KO_________________

Longest duration of unconsciousness ____

Length of time before resuming boxing after last knockout ___________________________

Have you ever been knocked unconscious for any reason other than boxing or MMA competition? ☐YES ☐NO
If yes, explain ____

Amateur record: _______ Win _______ Losses _______ Draw

Professional record: _______ Win _______ Losses _______ Draw

Have you ever had Rheumatic Fever? If yes, when were you discharged as cured? _________________________

List any previous “elimination” matches or “tough-man” events you have fought in: ___________________________

Results___________________________

List any other serious injuries that you have ever had: ____

Have you ever had a fight stopped for any medical reason? If yes, please specify___________________________

II. PHYSICAL EXAMINATION **Pages 3 & 4 to be completed by a physician**

Height __________ Weight __________ Temperature __________

OTOLOGIC External Trauma □ YES □ NO
Perforated Drum □ YES □ NO

NOSE Instability □ YES □ NO
Recent Trauma □ YES □ NO
Obstruction □ YES □ NO

ORAPHARYNX Loose Teeth □ YES □ NO

ADENOPATHY □ YES □ NO

FACE Recent Trauma □ YES □ NO
Jaw and Temporomandibular Joints □ Normal □ Abnormal

LUNGS (Rales) □ Normal □ Abnormal

TESTES □ Normal □ Abnormal

ABDOMEN Enlargement of Liver □ YES □ NO
Hernia □ YES □ NO
Enlargement of Spleen □ YES □ NO
Femoral □ Inguinal □ Ventral □

CARDIOVASCULAR Blood Pressure (supine) _______________ (upright) _______________
Blood Pressure after 100 hops ____________ Blood Pressure 2 minutes later ____________
Heart Rate (supine) _______________ (after 2 minutes of exercise) _______________

ENLARGE GLANDS □ YES □ NO **Goiter** □ YES □ NO

HEART Pulse Rhythm □ Regular □ Irregular
Enlargement □ YES □ NO
Apical impulse □ Heavy □ Normal
Murmurs □ YES □ NO

BREAST (Women Contestants) Mass □ YES □ NO Tenderness □ YES □ NO

GYNECOLOGICAL EXAMINATION (Women Contestants): □ Normal □ Abnormal

MUSCULOSKELETAL:

			Comments
Hands	□ Normal	□ Abnormal	______
Wrists	□ Normal	□ Abnormal	______
Elbows	□ Normal	□ Abnormal	______
Shoulder Girdle	□ Normal	□ Abnormal	______
Lower Extremities	□ Normal	□ Abnormal	______

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

Reflexes: Pupils: ______ Knee jerk: _______ Romberg: ________ Babinski: ________

Skin: Rash:_______ Boils: _______ Any other unhealed wounds: ________

Eye Examination: Vision without correction: Right:_____ Left: _____ Vision with correction: Right:_____ Left: _____

Visual fields: Right:_____ Left: _____

Does the applicant have any current or chronic illnesses, physical injuries, abnormalities or physical limitations?
□ YES □ NO

If yes, would these interfere in any manner with this person's ability to participate unarmed combat?
□ YES □ NO

If yes, what limitations should be placed on this person? ____

____

COMMENTS OF EXAMINING PHYSICIAN (Please check if the person is or is not medically cleared below)

____
____
____
____
____

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 contact sport,

I also attest that I do not have a professional relationship with, nor financial interest in the earnings of this individual.

____
(PRINT NAME OF EXAMINING PHYSICIAN – MD or DO)

____
(SIGNATURE OF EXAMINING PHYSICIAN)

____
(PHYSICIAN'S LICENSE NUMBER)

____
(ADDRESS OF PHYSICIAN)

____
(TELEPHONE NUMBER OF PHYSICIAN)

(Office Stamp or Business Card)

Physicals submitted without the above box checked by the attending physician will be returned for completion and will delay licensure.