South Carolina Department of Labor, Licensing and Regulation
South Carolina State Athletic Commission
110 Centerview Dr. • Columbia • SC • 29210
P.O. Box 11329 • Columbia • SC 29211-1329
Phone: 803-896-4571 • Contact.Athl@llr.sc.gov • Fax: 803-896-4350
llr.sc.gov/ath

MEDICAL HISTORY FORM

APPLICANT: Fill this form out then take to physician's office to have completed. This form must be sent in by the doctor's office; otherwise it will not be accepted.

Name: _____ Date of Birth: _____ Social Security: xxx-xx-_____

1. Are you taking any medications? Yes No What Kind? _____
2. Are you allergic to any medication? Yes No What Kind? _____
3. You must submit an original or certified laboratory report which indicates your name and is dated no later than one year prior to South Carolina event or exhibition. The report must indicate that you are HIV, Hepatitis B and C negative. (Wrestlers are excluded from this requirement)
4. Have you ever had any of the following? (Circle answer/answer all questions)

a.	Allergies	yes	no	l.	Heart Trouble	yes	no
b.	Asthma	yes	no	m.	Hernia	yes	no
c.	Bleeding Tendencies	yes	no	n.	Tuberculosis	yes	no
d.	Chronic Cough	yes	no	o.	Kidney Trouble	yes	no
e.	Dizzy or Fainting Spells	yes	no	p.	Rheumatic Fever	yes	no
f.	Diabetes	yes	no	q.	Shortness of Breath	yes	no
g.	Eye trouble	yes	no	r.	Skin Disease	yes	no
h.	Headaches	yes	no	s.	Chest Pain	yes	no
i.	Seizures	yes	no	t.	Psychiatric Problems	yes	no
j.	Hepatitis	yes	no	u.	Surgery	yes	no
k.	Neck Injuries	yes	no	v.	Spinal Injuries	yes	no

5. If yes to any of the above, please explain: _____
_____
6. Have you ever been unconscious? Yes No If Yes, when? _____
7. Have you ever sustained any neck, spinal or other injury or have any other information concerning your health, past or present, which is not covered by the previous questions? Yes No If yes, please explain and list the physician diagnosis and treatment. _____
_____
8. Have you had any injuries while training for this bout? Yes No
9. Have you consulted any doctor while training for this bout? Yes No Whom: _____
What treatment have you received? _____
10. Do you have personal medical and hospital insurance coverage? Yes No
Effective Date: _____ Company: _____

_____ _____
Applicant's Signature Date

PHYSICAL EXAMINATION
TO BE COMPLETED BY A MD OR DO ONLY

Doctor's Office should mail or fax both forms to our office. Please see page 1 for address or fax number.

Patient Name: _____ Date of Birth: _____ Social Security: **xxx-xx-** _____

Pulse: _____ Resp: _____ Height: _____ Weight: _____ BP: _____

Vision (Snellen Chart) **Corrected**: R eye: _____ L eye: _____ **Uncorrected**: R eye: _____ L eye: _____

VISUAL FIELDS	**N**	**X**
PERIORBITAL AREA		
Recent Scars	N	X
Tenderness	N	X
Contusions	N	X
HENT		
Drums	N	X
Nasopharnynx	N	X
Adenopathy	N	X
Cranial Nerves	N	X
Hearing	N	X
Nasal Airway	N	X
CHEST		
Chest X-Ray (if required)	N	X
Lungs	N	X
Heart	N	X
ABDOMEN		
Liver	N	X
Spleen	N	X
Hernia	N	X

NEUROLOGICAL		
EKG (if required)	N	X
EEG (if required)	N	X
MRI (if required)	N	X
CAT (if required)	N	X
GaitN	N	X
Romberg	N	X
Finger to Nose	N	X
Knee Jerk	N	X
Bicep Jerk	N	X
Babiniski	N	X
ORTHOPEDIC		
Flexibility	N	X
Other	N	X
HANDS		
Tenderness	N	X
Swelling	N	X
Deformity	N	X

Does applicant/licensee appear to be under the influence of any substance to include alcohol or drugs? (Circle One)

YES NO NOT SURE

Conditions which would disqualify the applicant/licensee from this license: _____

Physician Comments: _____

After completing the above physical examination and test results (Circle One):

I DO / I DO NOT feel the applicant/licensee is physically eligible to be licensed as a fighter.

_____ _____ _____

Signature of Examining Physician MD or DO License Number Date

_____ _____

Print or Stamp Name of MD or Do Phone Number (XXX) XXX-XXXX

_____ _____

Office Street Address, City, State, Zip Fax Number (XXX) XXX-XXXX