



South Carolina State Athletic Commission

PROFESSIONAL BOXER / MMA FIGHTER MEDICAL HISTORY FORM

Type or Print in Ink

Name: _____

Date of Birth: _____ Social Security Number: _____

1. Are you taking any medication? 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 the South Carolina event or exhibition. The report must indicate you are HIV, Hepatitis B and C negative. You must also complete an ophthalmologic exam. (Enclosed)

4. Have you ever had any of the following? (answer all questions)

- | | | | | | |
|-----------------------------|-----|----|-------------------------|-----|----|
| a. Allergies | yes | no | l. Heart Trouble | yes | no |
| b. Bleeding Tendencies | yes | no | m. Hernia | yes | no |
| c. Asthma | 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? _____ 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 diagnoses 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 (Wrestler/Boxer/Kick-Boxer)? Yes___ No___

If yes, what was the effective date? _____ Company: _____

Applicant's/Licensee Signature

Date

**Physical Examination
TO BE COMPLETED BY DOCTOR ONLY**

Pulse _____ Resp. _____ Height _____ Weight _____ Blood Pressure _____

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

EYES

Ophthalmoscopic exam N X
Optic disc N X
Retina N X
Central artery, vein N X

VISUAL FIELDS

PERIORBITAL AREA

Recent scars N X
Tenderness N X
Contusions N X

HENT

Drums N X
Nasopharynx 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

***SEROLOGY**

HIV, Hep B and C N X
Drug screen (if required) N X

ABDOMEN

Liver N X
Spleen N X
Hernia N X
Genitourinary N X

NEUROLOGICAL

EKG (if required) N X
EEG (if required) N X
MRI (if required) N X
CAT (if required) N X
Gait 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

(The original or certified laboratory report of negative results must be submitted.)

Does applicant/licensee appear to be under the influence of any substance to include drugs or alcohol? Yes ____ No ____ Not Sure ____

Conditions which would disqualify applicant/licensee from this event: _____

Physician Comments: _____

After completing the above physical examination and test results (CIRCLE CHOICES)

(I DO / I DO NOT) believe the applicant requires further medical tests.

(I DO / I DO NOT) feel the applicant licensee is physically eligible to participate in this event.

Signature of Examining Physician _____ M.D. or D.O

_____ Date

Print Name of Examining Physician (or stamp) _____

_____ License Number

Address _____

_____ Telephone