ATHLETE MEDICAL HISTORY
BOXING/MMA/KICKBOXING

Legal Name: ____ Federal/National ID#: _________________
Last First Middle

Address: ____
Street City State Zip Code Country

Telephone: ___________________ E-mail: _________________________ Date of Birth: ______/______/______

Sex: □ M □ F Emergency Contact: ______________________________ Emergency Phone: _________________

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

	Yes	No
Seizure, flashing lights	□	□
Headaches	□	□
Bleeding on or near the brain	□	□
Dizzy or passed out during exercise	□	□
Double or blurred vision	□	□
Retinal Detachment	□	□
Hearing difficulty	□	□
Broken nose	□	□
Chest pain	□	□
Irregular heart beat or murmur	□	□
Excessive muscle cramping, fatigue, or shortness of breath with exercise	□	□

	Yes	No
High blood pressure	□	□
Asthma or wheezing	□	□
Broken bones or recent sprains	□	□
Neck or back injury	□	□
Hernia	□	□
Cold sores, fever blisters or herpes	□	□
Diabetes	□	□
Bleeding problems	□	□
Hepatitis or liver problems	□	□
Heat stroke/heat exhaustion	□	□
Recent illness or fever	□	□
Sickle cell trait or disease	□	□

If "Yes" to any of the above, explain: ____

	Yes	No	
Have you ever had a concussion, a head injury, or lost consciousness?	□	□	______________________
Have you ever been restricted from sports due to a medical condition?	□	□	______________________
Do you or have you ever used steroids, testosterone, or banned substances?	□	□	______________________
Have you ever had any surgeries (including eye surgeries like LASIK or PRK)?	□	□	______________________
Do any diseases run in your family or has anyone died suddenly before age 50?	□	□	______________________
Have you seen a doctor for *any* medical problem in the last 3 months?	□	□	______________________
Do you have any other medical conditions or training/sparring injuries?	□	□	______________________
Do you presently smoke tobacco, marijuana or use illegal drugs?	□	□	______________________
Are you allergic to any medications or supplements?	□	□	______________________
Have you travelled to or from another country in the last 30 days?	□	□	______________________
Women only: Have you ever had any type of breast surgery?	□	□	______________________
Women only: Is there any chance you may be pregnant?	□	□	______________________

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

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

How many days' notice did you have for this bout? ___________ How far do you run a day (miles/km)? __________

How much weight do you usually lose for a bout? ___________ How much weight lost for this bout? ___________

Sport History In which sports do you compete? □ Boxing □ MMA □ Kickboxing □ Other: _______________

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 understand that this form is part of the licensing process. I authorize the Athletic Commission to have immediate and unlimited access to any and all medical records which may relate to my fitness to participate in boxing/mixed martial arts/kickboxing or to any injury or suspected injury. I have been training faithfully and am in good physical condition. The answers given above are true and correct to the best of my knowledge and belief. I understand the examining physician depends on the reliability of the statements made above and I am not withholding any information. I understand that all statements and information supplied by me are made under the penalty of perjury and if untrue or not informative may lead to penalty, suspension, and license revocation.

______________________________ ______________________________ _______________
Name (printed) Signature Date