**STATE OF HAWAII**
HAWAII MMA PROGRAM
**CONTESTANT'S PHYSICAL EXAMINATION**

**MUST BE COMPLETED AND SIGNED BY M.D. OR D.O.**

HAWAII MMA PROGRAM
P.O. BOX 3469
HONOLULU, HI 96801
PHONE NO. (808) 586-2701
FAX (808) 586-2874

| NAME (LAST, First, Middle) | | DATE OF EXAM |
|---|---|---|
| RING NAME | | SOCIAL SECURITY NO. |
| CURRENT ADDRESS (Include Apt. No., City, State & Zip Code) | TELEPHONE NO. | DATE OF BIRTH |
| | AGE | SEX: ◯ Male ◯ Female |

## MEDICAL HISTORY (PLEASE COMPLETE AS THOROUGHLY AS POSSIBLE)

HAS APPLICANT EVER HAD ANY OF THE FOLLOWING CONDITIONS? PLACE AN "X" IF IT APPLIES TO YOU.

| | | | |
|---|---|---|---|
| ☐ Fainting Spells | ☐ Rupture (hernia) | ☐ Chest Pain | ☐ Operations |
| ☐ Shortness of Breath | ☐ Swollen Joints | ☐ Rheumatism | ☐ Diabetes |
| ☐ Frequent Headaches | ☐ Convulsions (fits) | ☐ Chronic Cough | ☐ Bleeding Disorder |
| ☐ Spitting of Blood | ☐ Cerebral Hemorrhage or any other serious head injury | | |

1. HAVE YOU EVER BEEN HOSPITALIZED? ☐ Yes ☐ No If "Yes", give nature of problem(s), date(s), location(s) and attending physicians: _____

2. HAVE YOU EVER HAD EYE SURGERY? ☐ Yes ☐ No If "Yes", explain: _____

3. HAVE YOU EVER HAD A RETINAL DETACHMENT? ☐ Yes ☐ No If "Yes", explain: _____

4. DO YOU REGULARLY OR OCCASIONALLY TAKE ANY MEDICATIONS? ☐ Yes ☐ No
   If "Yes", give name(s), frequency and dose: _____

5. HAVE YOU PREVIOUSLY BEEN INJURED IN A BOXING/KICKBOXING/MARTIAL ARTS EVENT? ☐ Yes ☐ No
   If "Yes", describe injuries: _____

6. LONGEST DURATION OF UNCONSCIOUSNESS: _____

7. WHAT IS YOUR RECORD? Wins: _____ Losses: _____ Draws: _____

8. WHAT IS YOUR RECORD FOR THE LAST YEAR? Wins: _____ Losses: _____ Draws: _____ Number of times lost by TKO or KO? _____

9. WHEN WERE YOU LAST GIVEN A MEDICAL SUSPENSION FROM A COMMISSION/PROGRAM? Date: _____

10. WHY WERE YOU SUSPENDED? _____

11. (FEMALE CONTESTANTS ONLY) DATE OF LAST MENSTRUAL PERIOD? _____

## PHYSICAL EXAM

HEIGHT

WEIGHT

TEMPERATURE

**OTOLOGIC**

| | | |
|---|---|---|
| External Trauma | ☐ Yes | ☐ No |
| Perforated Drum | ☐ Yes | ☐ No |

**OROPHARYNX**

| | | |
|---|---|---|
| Loose Teeth | ☐ Yes | ☐ No |

**NOSE**

| | | |
|---|---|---|
| Instability | ☐ Yes | ☐ No |
| Recent Trauma | ☐ Yes | ☐ No |
| Obstruction | ☐ Yes | ☐ No |

**ABDOMEN**

| | | |
|---|---|---|
| Enlargement of Liver | ☐ Yes | ☐ No |
| Hernia | ☐ Yes | ☐ No |
| Enlargement of Spleen | ☐ Yes | ☐ No |

☐ Femoral ☐ Inguinal ☐ Ventral

**HEART**

| | | |
|---|---|---|
| Pulse Rhythm | ☐ Normal | ☐ Abnormal |
| Enlargement | ☐ Yes | ☐ No |
| Apical Impulse | ☐ Heavy | ☐ Normal |
| Murmurs | ☐ Yes | ☐ No |

**BREAST (FEMALE CONTESTANTS)**

| | | |
|---|---|---|
| Mass | ☐ Yes | ☐ No |
| Tenderness | ☐ Yes | ☐ No |

**GYNECOLOGICAL EXAM (FEMALES)**

☐ Normal ☐ Abnormal

** **SIGNATURES REQUIRED ON PAGE 2** **



This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

Print Name of Applicant: _____ Date: _____

| | | |
|---|---|---|
| **FACE** | | |
| Recent Trauma | ☐ Yes | ☐ No |
| Jaw and Temporomandibular Joints | ☐ Normal | ☐ Abnormal |
| **ADENOPATHY** | ☐ Yes | ☐ No |
| **LUNGS (RALES)** | ☐ Normal | ☐ Abnormal |
| **TESTES** | ☐ Normal | ☐ Abnormal |
| **ENLARGED GLANDS** | ☐ Yes | ☐ No |
| **GOITER** | ☐ Yes | ☐ No |

**CARDIOVASCULAR**

Blood Pressure (supine) _____ (upright) _____

Blood Pressure after 100 hops _____

Blood Pressure 2 minutes later _____

Heart Rate (supine) _____

Heart Rate (after 2 minutes of exercise) _____

**MUSCULOSKELETAL**

| | | | |
|---|---|---|---|
| Hands | ☐ Normal | ☐ Abnormal | Comments: _____ |
| Wrists | ☐ Normal | ☐ Abnormal | Comments: _____ |
| Elbows | ☐ Normal | ☐ Abnormal | Comments: _____ |
| Shoulder Girdle | ☐ Normal | ☐ Abnormal | Comments: _____ |
| Lower Extremities | ☐ Normal | ☐ Abnormal | Comments: _____ |

**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 |

**COMMENTS OF EXAMINING PHYSICIAN:** _____

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 professional boxing, kick boxing, martial arts contest or wrestling. I also attest that I do not have a professional relationship with, nor financial interest in the earnings of, this individual.

**MUST BE COMPLETED AND SIGNED BY M.D. OR D.O.**

| PRINT NAME OF EXAMING PHYSICIAN | PHYSICIAN'S LICENSE NO. | PHYSICIAN'S PHONE NO. |
|---|---|---|
| | | |

_____
SIGNATURE OF EXAMINIG PHYSICIAN

ADDRESS OF PHYSICIAN

## MEDICAL RELEASE OF INFORMATION

I hereby authorize the Hawaii MMA Program to release, disclose, and furnish to any other boxing or athletic commission affiliated with the Association of Boxing Commissions (ABC), any and all of my medical records concerning my licensure as a participant including, but not limited to, all required medical examinations, laboratory test results for the HIV, hepatitis virus and drug screening, hospital records, and any other information regarding conditions related to the propriety of my licensure as a participant (including history, findings, diagnosis, or prognosis).

I understand, and it is agreed, that the signing of this Medical Information Release is optional, and that my declining to sign this document will not result in any adverse action being taken against me by the Hawaii MMA Program based on my decision. I understand, and it is agreed, that the medical records described herein will not be released for any purpose other than for a member commission affiliated with the ABC to determine my eligibility to participate in a professional boxing, kick boxing, or martial arts events. I understand, and it is agreed, that this authorization shall remain in effect until June 30, of each odd numbered year and is relevant to all medical records described herein, whether such records were created prior to, or subsequent to, the date the authorization is signed.

By signing below, I hereby authorize the release of my medical information.

_____ _____
SIGNATURE OF CONTESTANT DATE

_____
PRINT NAME

Print Form