

STATE OF HAWAII
STATE BOXING COMMISSION OF HAWAII
CONTESTANT'S PHYSICAL EXAMINATION

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

STATE BOXING COMMISSION OF HAWAII
 335 MERCHANT STREET, ROOM 329
 HONOLULU, HI 96813
 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: <input type="radio"/> Male <input type="radio"/> 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.		
<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Rupture (hernia)	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Convulsions (fits)	<input type="checkbox"/> Chronic Cough
<input type="checkbox"/> Spitting of Blood	<input type="checkbox"/> Cerebral Hemorrhage or any other serious head injury	<input type="checkbox"/> Operations
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bleeding Disorder	
1. HAVE YOU EVER BEEN HOSPITALIZED? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes", give nature of problem(s), date(s), location(s) and attending physicians: _____		
2. HAVE YOU EVER HAD EYE SURGERY? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes", explain: _____		
3. HAVE YOU EVER HAD A RETINAL DETACHMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes", explain: _____		
4. DO YOU REGULARLY OR OCCASIONALLY TAKE ANY MEDICATIONS? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes", give name(s), frequency and dose: _____		
5. HAVE YOU PREVIOUSLY BEEN INJURED IN A BOXING/KICKBOXING/MARTIAL ARTS EVENT? <input type="checkbox"/> Yes <input type="checkbox"/> 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? _____		

**** SIGNATURES REQUIRED ON PAGE 3 ****

(CONTINUED ON PAGE 2)

Print Name of Applicant: _____

Date: _____

PHYSICAL EXAM					
HEIGHT	WEIGHT		TEMPERATURE		
OTOLOGIC		FACE			
External Trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Trauma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Perforated Drum	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw and Temporomandibular Joints	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
OROPHARYNX		ADENOPATHY		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Loose Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	LUNGS (RALES)		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
NOSE		TESTES		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Instability	<input type="checkbox"/> Yes <input type="checkbox"/> No	ENLARGED GLANDS		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Recent Trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No	GOITER		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Obstruction	<input type="checkbox"/> Yes <input type="checkbox"/> No	CARDIOVASCULAR			
ABDOMEN		Blood Pressure (supine) _____ (upright) _____			
Enlargement of Liver	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Pressure after 100 hops _____			
Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Pressure 2 minutes later _____			
Enlargement of Spleen	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Rate (supine) _____			
<input type="checkbox"/> Femoral <input type="checkbox"/> Inguinal <input type="checkbox"/> Ventral		Heart Rate (after 2 minutes of exercise) _____			
HEART					
Pulse Rhythm	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Apical Impulse	<input type="checkbox"/> Heavy	<input type="checkbox"/> Normal	
Enlargement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Murmurs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
BREAST (FEMALE CONTESTANTS)					
Mass	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tenderness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
GYNECOLOGICAL EXAMINATION (FEMALE CONTESTANTS)					
<input type="checkbox"/> Normal		<input type="checkbox"/> Abnormal			
MUSCULOSKELETAL					
Hands	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Comments: _____			
Wrists	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Comments: _____			
Elbows	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Comments: _____			
Shoulder Girdle	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Comments: _____			
Lower Extremities	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Comments: _____			
NEUROLOGIC					
Mental Status	Orientation _____ /3				
	5-minute recall _____ /3				
Cranial Nerves	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Strength	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
Tone	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Gait	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
Coordination: Finger to Nose	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Tandem Gait	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	

(CONTINUED ON PAGE 3)

Print Name of Applicant: _____

Date: _____

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 EXAMINING PHYSICIAN	PHYSICIAN'S LICENSE NO.	PHYSICIAN'S PHONE NO.
SIGNATURE OF EXAMINING PHYSICIAN		ADDRESS OF PHYSICIAN

MEDICAL RELEASE OF INFORMATION

I hereby authorize the State Boxing Commission of Hawaii 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 State Boxing Commission of Hawaii 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 December 31 of each calendar 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	