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? _____

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

(CONTINUED ON PAGE 2)

Print Name of Applicant: _____ Date: _____

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

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) _____

HEART

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

BREAST (FEMALE CONTESTANTS)

Mass	☐ Yes	☐ No	Tenderness	☐ Yes	☐ No

GYNECOLOGICAL EXAMINATION (FEMALE CONTESTANTS)

☐ Normal ☐ Abnormal

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

(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 EXAMING PHYSICIAN	PHYSICIAN'S LICENSE NO.	PHYSICIAN'S PHONE NO.
	ADDRESS OF PHYSICIAN	

_____
SIGNATURE OF EXAMINIG 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

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.