State of Rhode Island
DEPARTMENT OF BUSINESS REGULATION
1511 Pontiac Avenue, Bldg. 69-1
Cranston, Rhode Island 02920

Division of Gaming and Athletics Licensing

PHYSICAL EXAM PROFESSIONAL ATHLETE

Only a licensed Physician within the United States may conduct this examination and complete this form in its entirety.

BOXING: _________ MMA: _________

FIGHTER INFORMATION – TO BE COMPLETED BY THE FIGHTER.

Name:____
(FIRST (MI) (LAST)

Address:____
(STREET) (TOWN/CITY) (STATE) (ZIP CODE

CIRCLE ONE
Age: **Male / Female** **DOB**:

Physical History: (Please circle all that applies below)

Asthma   Blood in Urine   Allergies   Fainting spells   Rupture(hernia)   Chest Pains

Operations   Shortness of Breath   Swollen joints   Rheumatism   Diabetes   Frequent Headaches

Convulsions(fits)   Chronic Cough   Spitting of Blood   Cerebral Hemorrhage or serious head injury:

Please explain any of the above:

When was the last time you took any medication or drug? (STATE WHAT TYPE & WHEN, BE SPECIFIC):

Have you ever undergone any type of surgery? No____ Yes_____ (IF YES, WHAT TYPE & WHEN)

Professional Record:
Wins:__________ Losses:__________ Losses by TKO/KO:__________

Date you last loss by TKO or KO:_____________**Date of your last Fight**:_______________

AFFIRMATION
(TO BE COMPLETED BY THE FIGHTER)
I hereby swear or affirm, under penalties of perjury, that the statement made in this report are true, complete and correct.

SIGNATURE OF FIGHTER	PRINTED NAME OF FIGHTER	DATE:
X		

Tel: 401-462-9525   Fax: 401-462-9645   TTY: 711   Web Site: www.dbr.ri.gov

PHYSICAL EXAM PROFESSIONAL ATHLETE

APPLICANT'S NAME:_______________________________________ EXAM DATE:__________________

TO BE COMPLETED BY MEDICAL DOCTOR/PHYSICIAN

PHYSICAL EXAMINATION:

GENERAL APPEARANCE: **HEIGHT:** **WEIGHT:** **TEMP:**

BLOOD PRESSURE: **PULSE:** **RESP:**

MEDICATIONS:

SYSTEM REVIEW: (Circle if Abnormal)

CONSTITUTIONAL	SKIN	HEAD/EYES	EARS/NOSE/THROAT/NECK
Fevers	**Rash**	**Changes in Vision**	**Difficulty Hearing Swollen Nodes**
Chills	**Moles**	**Hair loss**	**Ringing in Ears Stiffness**
Sweats	**Flushing**	**Purtis**	**Congestion Sinus Pain**
Excessive Thirst	**Dry Skin**		**Gum/Teeth Problems**
Fatigue/Change in Energy	**Lesions**		**Swallowing Difficulties**
	Bruising		**Hay Fever/Allergies**
	Lumps		**Thyroid**
HEART	LUNGS	CHEST WALL	GI
Palpitations	**Shortness of Breath**	**Pain**	**Abdominal Pain Hemmorrhoids**
Chest Pains	**Wheezing**	**Lumps**	**Change in appetite N/V**
Rapid Rate	**Cough**	**Nipple Discharge**	**Constipation Weight Loss**
Fainting	**Exertional Dyspnea**	**Rib Strain**	**Diarrhea Weight Gain**
Edema	**Orthopnea**	**Masses**	**Chg in Bowl Habbits GERD**
Ectopy	**CTA**		**Blood in Stool Dysphasia**
GU	BONE/JOINT	CNS/PSYCH	EXTREMITY
Frequent Urination	**Muscle Pains**	**Headaches**	**Swelling**
Nighttime Urination	**Cramps**	**Dizziness**	**Fungus**
Leakage	**Spasms**	**Memory Loss**	**Varicosities**
Burning/Urgency	**Restless Leg**	**Numbness**	**Change in Coordination**
Discharge	**Weakness**	**Anxiety**	
Sexual Dysfunction	**Back Pain**	**Insomnia**	GENITALIA
		Depression	**External Hernia**
		Tremor	**Testicular Mass Lesions**
		Vertigo	**Rectal Deferred**

COMMENTS:

Must be completed and signed by an MD or DO within the United States!!!!!

The above fighter: IS_______ IS NOT________ Medically cleared to participate/fight.

Physician's Name

Print:____________________________________ Physician's Name Signature:________________________

Address:____City/Town____________________________________

State:__________ Zip:____________ Telephone #:____

(Created by Dr. Michael Schwartz)