New York State
**Department of State**
**State Athletic Commission**
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NEW YORK STATE OF OPPORTUNITY.

# New York State Athletic Commission

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**Department of State**
**State Athletic Commission**
123 William Street
New York, NY 10038-3804
Telephone: (212) 417-5700
www.dos.ny.gov/athletic

## History and Physical Examination Record for a Combative Sport Professional

### SECTION 1 — TO BE COMPLETED BY COMBATIVE SPORT PROFESSIONAL

**Personal History**

THIS IS MY (CHECK ONLY ONE BOX): ❑ First Application ❑ Renewal Application

TODAY'S DATE

1. LEGAL NAME
2. RING NAME
3. STREET ADDRESS (HOME)
TELEPHONE #
EMAIL ADDRESS
CITY
STATE
ZIP CODE + 4
4. DATE OF BIRTH
5. COUNTRY OF BIRTH
6. Sex:
7. Are you a U.S. citizen? ❑ YES ❑ NO
8. MANAGER'S NAME
9. TRAINER'S NAME ❑ MALE ❑ FEMALE

10. CIRCLE THE HIGHEST YEAR OF SCHOOLING YOU HAVE **COMPLETED**

ELEMENTARY 1 2 3 4 5 6 7 8 HIGH SCHOOL 9 10 11 12

COLLEGE 1 2 3 4 OTHER: _____

**Fighting History**

11. PRESENT WEIGHT DIVISION
12. NUMBER OF YEARS YOU HAVE BEEN FIGHTING — AMATEUR — PROFESSIONAL
13. YOUR AGE AT FIRST FIGHT
14. PROFESSIONAL FIGHTING RECORD — WON — LOST — DRAW
15. NUMBER OF AMATEUR FIGHTS
16. DATE OF LAST BOUT
OUTCOME

17. Have you ever been knocked out or suffered a TKO during a match? . . . . . ❑ YES* ❑ NO

*If YES, explain: _____

18. Have you ever been suspended medically after a match? . . . . . ❑ YES* ❑ NO

*If YES, explain: _____

19. Have you ever been hospitalized after a match? . . . . . ❑ YES* ❑ NO

*If YES, explain: _____

21. How many rounds do you spar/full contact during one week? . . . . . _____
22. In which states are you licensed to fight professionally? _____
23. How many weeks in advance do you prepare for a bout? . . . . . _____
24. How much weight do you lose in preparation for a bout? . . . . . _____
25. How many days prior to a match do you stop sparring/full contact sparring?. . . . . _____
26. Do you use a sauna to lose weight? . . . . . ❑ YES ❑ NO
27. Do you use diuretics or water pills prior to a bout to lose weight? . . . . . ❑ YES ❑ NO
28. Primary gym name, address and telephone #: _____

**Medical History**

29. Have you ever been unconscious for any reason? . . . . . ❑ YES* ❑ NO

*If YES, explain: _____

30. Do you have any skin problems? . . . . . ❑ YES ❑ NO
31. Do you bruise easily (get black and blue marks)? . . . . . ❑ YES ❑ NO
32. Have you ever been treated for alcohol or drug abuse? . . . . . ❑ YES ❑ NO
33. Did you ever suffer a nervous breakdown or emotional problems? . . . . . ❑ YES ❑ NO
34. Do you suffer from headaches, dizziness or memory problems? . . . . . ❑ YES ❑ NO
35. Have you ever had epilepsy (convulsions, fits or seizures)? . . . . . ❑ YES ❑ NO
36. Have you ever suffered a sudden loss of vision? . . . . . ❑ YES ❑ NO

**SECTION 1 CONTINUED — TO BE COMPLETED BY COMBATIVE SPORT PROFESSIONAL**

37. Do you suffer from blurred, defective or double vision? . . . . . ❑ YES ❑ NO
38. Have you ever suffered from a ringing or buzzing noise in your ears? . . . . . ❑ YES ❑ NO
39. Have you ever suffered from decreased hearing? . . . . . ❑ YES ❑ NO
40. Do you have a well fitted mouthpiece? . . . . . ❑ YES ❑ NO
41. Do you wear contact lenses during competition? .. . . . . ❑ YES ❑ NO
42. Do you have any allergies? . . . . . ❑ YES* ❑ NO

*If YES, explain: _____

43. Do you suffer from shortness of breath or irregular beating of the heart? . . . . . ❑ YES ❑ NO
44. Do you smoke? . . . . . ❑ YES ❑ NO
45. Do you suffer pain or pressure (heaviness) in the chest? . . . . . ❑ YES ❑ NO
46. Have you ever been told that you have heart disease? . . . . . ❑ YES ❑ NO
47. Have you ever coughed up blood or been told that you have lung disease? . . . . . ❑ YES ❑ NO
48. Do you have a cough or wheezing? . . . . . ❑ YES ❑ NO
49. Have you ever been told that you have an ulcer or any other abdominal disease? . . . . . ❑ YES ❑ NO
50. Have you ever suffered from any bone-joint disease? . . . . . ❑ YES ❑ NO
51. Have you ever suffered from any back, neck, shoulder, arm or leg injuries? . . . . . ❑ YES ❑ NO
52. Do you have any difficulties with bowel movements or urination? . . . . . ❑ YES ❑ NO
53. Have you ever been treated for venereal disease (e.g., syphilis, gonorrhea)? . . . . . ❑ YES ❑ NO
54. Have you ever had any illness or surgery which required hospitalization? . . . . . ❑ YES* ❑ NO
55. Have you ever had any surgeries or procedures involving your eyes, including Lasik surgery? . . . ❑ YES* ❑ NO

*If YES, please provide details of the illness or surgery (such as type of surgery or illness, dates of hospitalization, etc.) _____

_____

56. Have you ever been hospitalized? . . . . . ❑ YES ❑ NO
57. Have you seen a doctor, dentist or any health professional in the past year? . . . . . ❑ YES ❑ NO
58. Do you or any member of your family have sickle cell anemia? . . . . . ❑ YES ❑ NO
59. Has any member of your family had any neurological or brain disorders? . . . . . ❑ YES ❑ NO
60. Have you any other information concerning your health — ***past*** and ***present*** — which has not been covered by the above questions? . . . . . ❑ YES ❑ NO
61. Have you taken any medications, supplements or drugs during the past 30 days? … . . . . . ❑ YES* ❑ NO

*If Yes, please list: _____

_____

*Comments, if any*:

**Applicant Certification** — I hereby certify that the above statements are true and correct to the best of my knowledge and belief. I further understand that all statements and information supplied by me are made under the penalty of perjury and, if untrue and not informative, will lead to penalty and/or suspension.

_____
*Applicant Print Name*

**X** _____ _____
*Applicant Signature* *Date*

**X** _____
*Physician Print Name*

**X** _____ _____
*Physician Signature* *Date*

*Physician License Number:* _____ *State and County of Licensee* _____

_____ _____
*Reviewed by (Physician)* *Date*

## SECTION 2 — PHYSICAL EXAMINATION — TO BE COMPLETED BY EXAMINING PHYSICIAN

**1. VITAL SIGNS**

| A) BLOOD PRESSURE | B) PULSE (AT REST) | C) PULSE (AFTER 20 HOPS) | D) PULSE (2 MINUTES AFTER EXERCISE) |
|---|---|---|---|
| | | | |

COMMENT

**2. HEAD AND FACE (Describe scars, swelling, tenderness, etc.)** ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

**3. EYES**

A) RETINA ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

B) CORNEA AND CONJUNCTIVEA ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

C) VISUAL ACUITY (SNELLEN CHART)

| | RIGHT | LEFT | RIGHT | LEFT |
|---|---|---|---|---|
| UNCORRECTED: | | | CORRECTED: | |

D) SACCADES

HORIZONTAL ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

VERTICAL ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

**4. EARS (**Including **tympanic membrane, external auditory canals, auditory acuity for conversational voice)** ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

**5. NOSE** ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

**6. OROPHARYNX** ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

**7. NECK** ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

**8. LUNGS** ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

**9. THORAX/CHEST** ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

**10. HEART** ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

**11. ABDOMEN and INGUINAL AREA** ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

## SECTION 2 CONTINUED — TO BE COMPLETED BY EXAMINING PHYSICIAN

**12. BACK and SPINE** ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

**13. EXTREMITIES/MUSCULOSKELETAL SYSTEM**

| | | | | | |
|---|---|---|---|---|---|
| A) SHOULDERS | ❑ LEFT | ❑ NORMAL | ❑ ABNORMAL | ❑ NOT EXAMINED | |
| | ❑ RIGHT | ❑ NORMAL | ❑ ABNORMAL | ❑ NOT EXAMINED | |
| B) ELBOWS | ❑ LEFT | ❑ NORMAL | ❑ ABNORMAL | ❑ NOT EXAMINED | |
| | ❑ RIGHT | ❑ NORMAL | ❑ ABNORMAL | ❑ NOT EXAMINED | |
| C) HANDS/WRISTS | ❑ LEFT | ❑ NORMAL | ❑ ABNORMAL | ❑ NOT EXAMINED | |
| | ❑ RIGHT | ❑ NORMAL | ❑ ABNORMAL | ❑ NOT EXAMINED | |
| D) KNEES | ❑ LEFT | ❑ NORMAL | ❑ ABNORMAL | ❑ NOT EXAMINED | |
| | ❑ RIGHT | ❑ NORMAL | ❑ ABNORMAL | ❑ NOT EXAMINED | |
| E) ANKLES/FEET | ❑ LEFT | ❑ NORMAL | ❑ ABNORMAL | ❑ NOT EXAMINED | |
| | ❑ RIGHT | ❑ NORMAL | ❑ ABNORMAL | ❑ NOT EXAMINED | |

**14. SKIN** ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

**15. LYMPHATIC SYSTEM** ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

**16. NERVOUS SYSTEM — CRANIAL NERVES**

| | | | | |
|---|---|---|---|---|
| A) | VISUAL FIELD ..... | ❑ NORMAL | ❑ ABNORMAL | ❑ NOT EXAMINED |
| B) | PUPILLARY REACTION (also NOTE ANY PTOSIS) ..... | ❑ NORMAL | ❑ ABNORMAL | ❑ NOT EXAMINED |
| C) | EXTRAOCULAR MOVEMENTS (also NOTE NYSTAGMUS) ..... | ❑ NORMAL | ❑ ABNORMAL | ❑ NOT EXAMINED |
| D) | FACIAL SYMMETRY ..... | ❑ NORMAL | ❑ ABNORMAL | ❑ NOT EXAMINED |
| E) | GAG REFLEX and TONGUE ..... | ❑ NORMAL | ❑ ABNORMAL | ❑ NOT EXAMINED |

17. MOTOR FUNCTION ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

18. COORDINATION (Finger to Nose, Heel to Knee — rapid successive movements) ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

19. GAIT/ROMBERG ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

## SECTION 2 CONTINUED – TO BE COMPLETED BY EXAMINING PHYSICIAN

20. REFLEXES ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

### 21. MENTAL STATUS

**A. Orientation** (1pt. for each correct)

| | | |
|---|---|---|
| What month is it? | 0 | 1 |
| What is today's date? | 0 | 1 |
| What day of the week is it? | 0 | 1 |
| What year is it? | 0 | 1 |
| What time is it right now? (within 1 hr.) | 0 | 1 |

Orientation score ___ of 5

**B. Immediate Memory** (1pt. for each correct)

| List | Trial 1 | Trial 2 | Trial 3 | Alternative Words | | |
|---|---|---|---|---|---|---|
| Elbow | Y N | Y N | Y N | candle | baby | finger |
| Apple | Y N | Y N | Y N | paper | monkey | penny |
| Carpet | Y N | Y N | Y N | sugar | perfume | blanket |
| Saddle | Y N | Y N | Y N | table | sunset | lemon |
| Bubble | Y N | Y N | Y N | wagon | iron | insect |

**(Circle all words used. The athlete should repeat words in order. Complete all 3 trials regardless of score on trial 1& 2. Do not inform the athlete that delayed recall will be tested. Total score equals sum across all 3 trials).**

Immediate memory score ___ of 15

**C. Concentration**

| Digits Backwards (1 pt. possible for each string length) | | Alternative digit list | | |
|---|---|---|---|---|
| 4-9-3 | Y N | 6-2-9 | 5-2-6 | 4-1-5 |
| 3-8-1-4 | Y N | 3-2-7-9 | 1-7-9-5 | 4-9-6-8 |
| 6-2-9-7-1 | Y N | 1-5-2-8-6 | 3-8-5-2-7 | 6-1-8-4-3 |
| 7-1-8-4-6-2 | Y N | 5-3-9-1-4-8 | 8-3-1-9-6-4 | 7-2-4-8-5-6 |

Months in Reverse Order {1 pt. for entire sequence correct)
Dec-Nov-Oct-Sept-Aug-Jul-Jun-May-Apr-Mar-Feb-Jan Y N

Concentration score ___ of 5

**D. Delayed Recall**

*Ask athlete to recall the list of words read earlier in any order.*

| | | | |
|---|---|---|---|
| Elbow | candle | baby | finger |
| Apple | paper | monkey | penny |
| Carpet | sugar | perfume | blanket |
| Saddle | table | sunset | lemon |
| Bubble | wagon | iron | insect |

Delayed recall score ___ of 5

**TOTAL POINT SCORE ___ / 30**

❑ If applicant scores **less than 22 points** on the mental status examination, further neurological work-up is indicated unless the score can be explained on the basis of education and/or a language barrier (please note explanation on page 6 of 6)

*21. MENTAL STATUS, continued . . .*

**Explanation of score less than 22 points:**

## DIAGNOSTIC EVALUATION

| | Brain Scan | EKG | Hematology | Eye Exam | HIV | HBSAG | HCAB |
|---|---|---|---|---|---|---|---|
| DATE | | | | | | | |
| RESULT | | | | | | | |

**Physician's Certification —** I hereby certify that I have examined (*print full legal and ring name of applicant*)

on this day, (*insert date*)_____, and have found that:

____ **There are no abnormalities** on this applicant's physical examination that contraindicate participation in combat sports or mixed martial arts.

____ **There are abnormalities** on this applicant's physical examination that contraindicate participation in combat sports or mixed martial arts (*specify*):

*Name of Physician (PRINT)*: _____

*Signature of Physician*: **X** _____

*Office Address*: _____

_____

*Office Telephone Number*: _____