

**MANITOBA COMBATIVE SPORTS COMMISSION
COMPLETE PHYSICAL EXAMINATION**

Last name: _____ First name: _____ Middle initial: _____
 Street address: _____
 City: _____ Province: _____ Postal code: _____
 Telephone no. (include area code): _____
 Medical insurance no.: _____ Date of birth (day/month/year): _____
 Fight record: Won: _____ Lost: _____ Draw: _____ Date of last bout (day/month/year): _____
 Number of times knocked unconscious: _____

PAST MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
1. Problems/injuries to eyes	<input type="checkbox"/>	<input type="checkbox"/>	8. Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	15. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
2. Migraines	<input type="checkbox"/>	<input type="checkbox"/>	9. Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	16. Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>
3. Concussion	<input type="checkbox"/>	<input type="checkbox"/>	10. Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	17. Pinched nerve	<input type="checkbox"/>	<input type="checkbox"/>
4. Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	11. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	18. Seizures	<input type="checkbox"/>	<input type="checkbox"/>
5. Facial injuries	<input type="checkbox"/>	<input type="checkbox"/>	12. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	19. Broken bone(s)	<input type="checkbox"/>	<input type="checkbox"/>
6. Thyroid disorders	<input type="checkbox"/>	<input type="checkbox"/>	13. Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	20. Previous surgery	<input type="checkbox"/>	<input type="checkbox"/>
7. Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	14. Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	21. Other medical problems	<input type="checkbox"/>	<input type="checkbox"/>

If answered Yes above, please elaborate: _____

 Present medication(s) (list): _____ Allergies: _____

FAMILY MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
1. Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	5. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	9. Mental disorder	<input type="checkbox"/>	<input type="checkbox"/>
2. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	6. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	10. Seizures	<input type="checkbox"/>	<input type="checkbox"/>
3. Thyroid disorders	<input type="checkbox"/>	<input type="checkbox"/>	7. Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	11. Death at a young age	<input type="checkbox"/>	<input type="checkbox"/>
4. Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	8. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	12. Sudden death during exercise	<input type="checkbox"/>	<input type="checkbox"/>
						13. Other medical problems	<input type="checkbox"/>	<input type="checkbox"/>

If answered yes above, please elaborate: _____

WEIGHT (LBS): _____ HEIGHT (FEET/INCHES): _____ Male Female
 GENERAL APPEARANCE: _____ B.P. (sitting): _____ (supine): _____
 PULSE: _____ Beats/Min REGULAR IRREGULAR

ENT	NORMAL: <input type="checkbox"/> ABNORMAL: <input type="checkbox"/> COMMENTS: _____
Neck (thyroid, larynx, masses)	NORMAL: <input type="checkbox"/> ABNORMAL: <input type="checkbox"/> COMMENTS: _____
Lungs (breath sounds, chest wall, ribs)	NORMAL: <input type="checkbox"/> ABNORMAL: <input type="checkbox"/> COMMENTS: _____
CV (heart sounds, murmurs, pulses)	NORMAL: <input type="checkbox"/> ABNORMAL: <input type="checkbox"/> COMMENTS: _____

Abdominal/ inguinal	NORMAL: <input type="checkbox"/> ABNORMAL: <input type="checkbox"/> COMMENTS:																								
Rectal/genitalia	NORMAL: <input type="checkbox"/> ABNORMAL: <input type="checkbox"/> COMMENTS:																								
Spine/pelvis	NORMAL: <input type="checkbox"/> ABNORMAL: <input type="checkbox"/> COMMENTS:																								
Joints/extremities	NORMAL: <input type="checkbox"/> ABNORMAL: <input type="checkbox"/> COMMENTS:																								
Mental status	NORMAL: <input type="checkbox"/> ABNORMAL: <input type="checkbox"/> COMMENTS:																								
Cranial nerves	<table border="0"> <tr> <td></td> <td>Normal</td> <td>Abnormal</td> <td>Comments:</td> </tr> <tr> <td>Pupillary reaction</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Extra-ocular movements</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Facial symmetry</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Facial sensation</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Gag reflex/tongue</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> </table>		Normal	Abnormal	Comments:	Pupillary reaction	<input type="checkbox"/>	<input type="checkbox"/>	_____	Extra-ocular movements	<input type="checkbox"/>	<input type="checkbox"/>	_____	Facial symmetry	<input type="checkbox"/>	<input type="checkbox"/>	_____	Facial sensation	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gag reflex/tongue	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Gag reflex/tongue	<input type="checkbox"/>	<input type="checkbox"/>	_____																						
Motor function	NORMAL: <input type="checkbox"/> ABNORMAL: <input type="checkbox"/> COMMENTS:																								
Sensory function	NORMAL: <input type="checkbox"/> ABNORMAL: <input type="checkbox"/> COMMENTS:																								
Gait/Rhomberg	NORMAL: <input type="checkbox"/> ABNORMAL: <input type="checkbox"/> COMMENTS:																								
Reflexes (sup. and deep/Babinski)	NORMAL: <input type="checkbox"/> ABNORMAL: <input type="checkbox"/> COMMENTS:																								
Feet	NORMAL: <input type="checkbox"/> ABNORMAL: <input type="checkbox"/> COMMENTS:																								
Hands	NORMAL: <input type="checkbox"/> ABNORMAL: <input type="checkbox"/> COMMENTS:																								
Hearing	NORMAL: <input type="checkbox"/> ABNORMAL: <input type="checkbox"/> COMMENTS:																								
Breasts (female)	NORMAL: <input type="checkbox"/> ABNORMAL: <input type="checkbox"/> COMMENTS:																								

Diagnostic evaluation

(A) Blood testing required:

- HIV
 - Hepatitis B (antigen report required even if immunized)
 - Hepatitis C
- (Note: results valid only 90 days prior to event.)

(B) Pregnancy (Note: test no more than 7 days prior to event.)

I hereby certify that I have examined _____
(print full legal name)
on this date (day/month/year) _____.

Must check one

- There are **no** abnormalities in his or her physical examination that contraindicate competing in professional boxing or combat sports at this time.
- There **are** abnormalities in his or her physical examination that contraindicate competing in professional boxing or combat sports at this time.

Recommendations: _____

Name of physician (print): _____

Office address: _____

Telephone no. (including area code): _____ Fax: _____

E-mail: _____

Physician signature: _____

**MANITOBA COMBATIVE SPORTS COMMISSION
EYE EXAMINATION**

(Form must be completed by optometrist or ophthalmologist)

Last name: _____	
First name: _____	Middle initial: _____
Street address: _____	
City: _____	Province: _____
Postal code: _____	
Telephone no. (include area code): _____	
Medical insurance no.: _____	
Date of birth (day/month/year): _____	

REFRACTIVE STATE: (R) _____ (L) _____
VISUAL FIELDS: (R) _____ (L) _____
VISUAL ACUITY: (R) ___/___ (L) ___/___ BOTH ___/___ Completed <input type="checkbox"/> Uncorrected <input type="checkbox"/>
FUNDI: _____ CORNEA: _____ INTRA-OCULAR PRESSURE: _____
<u>Must check one</u>
Fit to compete in professional boxing or combat sports at this time: Yes <input type="checkbox"/> No <input type="checkbox"/>
If no, please explain: _____
Optometrist or Ophthalmologist (signature): _____
Date: _____
Optometrist or Ophthalmologist (print name): _____
Office address: _____
Telephone no. (including area code): _____ Fax: _____
E-mail: _____