



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

**Division of Commercial Licensing and  
Racing and Athletics**

**PHYSICAL EXAM PROFESSIONAL ATHLETE**

**Only a licensed Physician may conduct this examination and complete this form in its entirety.**

Please Circle One:

**BOXING      MIXED MARTIAL ARTS      KICKBOXING**

**FIGHTER INFORMATION – TO BE COMPLETED BY THE FIGHTER.**

<b>Name:</b> _____		
(FIRST)	(MI)	(LAST)
<b>Address:</b> _____		
(STREET)	(TOWN/CITY)	(STATE) (ZIP CODE)
CIRCLE ONE		
<b>Age:</b>	<b>Male / Female</b>	<b>DOB:</b>
<b>Physical History:</b> (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:		
_____		
_____		
<b>When was the last time you took any medication or drug?</b> (STATE WHAT TYPE & WHEN, BE SPECIFIC):		
_____		
<b>Have you ever undergone any type of surgery?</b> No____ Yes____ (IF YES, WHAT TYPE & WHEN)		
_____		
<b>Professional Record:</b>		
Wins:_____	Losses:_____	Losses by TKO/KO:_____
<b>Date you last loss by TKO or KO:</b> _____ <b>Date of your last Fight:</b> _____		
<b>AFFIRMATION</b> (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.		
<b>SIGNATURE OF FIGHTER</b>	<b>PRINTED NAME OF FIGHTER</b>	<b>DATE:</b>
<b>X</b>		

**PHYSICAL EXAM PROFESSIONAL ATHLETE**

APPLICANT'S NAME: \_\_\_\_\_ EXAM DATE: \_\_\_\_\_

TO BE COMPLETED BY MEDICAL DOCTOR/PHYSICIAN			
<b>PHYSICAL EXAMINATION:</b>			
<b>GENERAL APPEARANCE:</b>		<b>HEIGHT:</b>	<b>WEIGHT:</b>
<b>BLOOD PRESSURE:</b>		<b>PULSE:</b>	<b>RESP:</b>
<b>MEDICATIONS:</b>			
<b>SYSTEM REVIEW: (Circle if Abnormal)</b>			
<u>CONSTITUTIONAL</u>	<u>SKIN</u>	<u>HEAD/EYES</u>	<u>EARS/NOSE/THROAT/NECK</u>
Fevers	Rash	Changes in Vision	Difficulty Hearing Swollen Nodes
Chills	Moles	Hair loss	Ringing in Ears Stiffness
Sweats	Flushing	Puritis	Congestion Sinus Pain
Excessive Thirst	Dry Skin		Gum/Teeth Problems
Fatigue/Change in Energy	Lesions		Swallowing Difficulties
	Bruising		Hay Fever/Allergies
	Lumps		Thyroid
<u>HEART</u>	<u>LUNGS</u>	<u>CHEST WALL</u>	<u>GI</u>
Palpitations	Shortness of Breath	Pain	Abdominal Pain Hemorrhoids
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
<u>GU</u>	<u>BONE/JOINT</u>	<u>CNS/PSYCH</u>	<u>EXTREMITY</u>
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	<u>GENITALIA</u>
		Depression	External Hernia
		Tremor	Testicular Mass Lesions
		Vertigo	Rectal Deferred
<b>COMMENTS:</b>			

**Must be completed and signed by an MD or DO !!!!**

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)

Tel: 401-462-9506

Fax: 401-462-9645

TTY: 711

Web Site: www.dbr.ri.gov