MANITOBA COMBATIVE SPORTS COMMISSION
427-145 Pacific Ave Winnipeg MB R3B 276 Tel. (431) 877-MCSC (6272)

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	☐	☐	8. Heart disease	☐	☐	15. Diabetes	☐	☐
2. Migraines	☐	☐	9. Heart murmur	☐	☐	16. Bleeding disorders	☐	☐
3. Concussion	☐	☐	10. Irregular heart beat	☐	☐	17. Pinched nerve	☐	☐
4. Hearing problems	☐	☐	11. High blood pressure	☐	☐	18. Seizures	☐	☐
5. Facial injuries	☐	☐	12. Asthma	☐	☐	19. Broken bone(s)	☐	☐
6. Thyroid disorders	☐	☐	13. Ulcers	☐	☐	20. Previous surgery	☐	☐
7. Fainting spells	☐	☐	14. Kidney disease	☐	☐	21. Other medical problems	☐	☐

If answered Yes above, please elaborate: _____

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

FAMILY MEDICAL HISTORY

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

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: ☐ ABNORMAL: ☐ COMMENTS:
Neck (thyroid, larynx, masses)	NORMAL: ☐ ABNORMAL: ☐ COMMENTS:
Lungs (breath sounds, chest wall, ribs)	NORMAL: ☐ ABNORMAL: ☐ COMMENTS:
CV (heart sounds, murmurs, pulses)	NORMAL: ☐ ABNORMAL: ☐ COMMENTS:

Abdominal/ inguinal	NORMAL: ☐ ABNORMAL: ☐ COMMENTS:
Rectal/genitalia	NORMAL: ☐ ABNORMAL: ☐ COMMENTS:
Spine/pelvis	NORMAL: ☐ ABNORMAL: ☐ COMMENTS:
Joints/extremities	NORMAL: ☐ ABNORMAL: ☐ COMMENTS:
Mental status	NORMAL: ☐ ABNORMAL: ☐ COMMENTS:
Cranial nerves	Normal / Abnormal / Comments: Pupillary reaction ☐ ☐ _____ Extra-ocular movements ☐ ☐ _____ Facial symmetry ☐ ☐ _____ Facial sensation ☐ ☐ _____ Gag reflex/tongue ☐ ☐ _____
Motor function	NORMAL: ☐ ABNORMAL: ☐ COMMENTS:
Sensory function	NORMAL: ☐ ABNORMAL: ☐ COMMENTS:
Gait/Rhomberg	NORMAL: ☐ ABNORMAL: ☐ COMMENTS:
Reflexes (sup. and deep/Babinski)	NORMAL: ☐ ABNORMAL: ☐ COMMENTS:
Feet	NORMAL: ☐ ABNORMAL: ☐ COMMENTS:
Hands	NORMAL: ☐ ABNORMAL: ☐ COMMENTS:
Hearing	NORMAL: ☐ ABNORMAL: ☐ COMMENTS:
Breasts (female)	NORMAL: ☐ ABNORMAL: ☐ 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 ☐ Uncorrected ☐

FUNDI: _____ CORNEA: _____ INTRA-OCULAR PRESSURE: _____

Must check one

Fit to compete in professional boxing or combat sports at this time: Yes ☐ No ☐

If no, please explain: _____

Date: _____

Optometrist or Ophthalmologist (signature): _____

Optometrist or Ophthalmologist (print name): _____

Office address: _____

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

E-mail: _____