

PETE SUAZO UTAH ATHLETIC COMMISSION (PSUAC)

CONTESTANT MEDICAL HISTORY FORM

APPLICANT INFORMATION (to be completed by contestant)

MALE

FEMALE

Last Name _____ First Name _____ Middle _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip _____

Home Phone Number (____) _____ Mobile Phone Number (____) _____

Business Phone Number (____) _____ Email Address _____

Height _____ Weight _____ Eye Color _____ Hair Color _____

MEDICAL HISTORY (to be completed by contestant)

1. Are you taking any prescription/non-prescription medications? Yes No
If yes, which ones? _____

2. Are you allergic to any medications? Yes No If yes, which ones? _____

3. Have you ever had any of the following? (answer all questions)

a. Allergies	yes	no	m. Heart Trouble	yes	no
b. Bleeding Tendencies	yes	no	n. Hernia	yes	no
c. Asthma	yes	no	o. Tuberculosis	yes	no
d. Chronic Cough	yes	no	p. Kidney Trouble	yes	no
e. Dizzy or Fainting Spells	yes	no	q. Rheumatic Fever	yes	no
f. Diabetes	yes	no	r. Shortness of Breath	yes	no
g. Vision Problems	yes	no	s. Skin Disease	yes	no
h. Frequent Headaches	yes	no	t. Chest Pain	yes	no
i. Seizures/Convulsions	yes	no	u. Psychiatric Problems	yes	no
j. Hepatitis	yes	no	v. Surgery/Operations	yes	no
k. Neck Injuries	yes	no	x. Spinal Injuries	yes	no
l. Palpitations (racing heart rate)	yes	no	y. Serious Head Injury	yes	no

4. If "yes" to any of the above, please explain: _____

5. Total number of knockouts received: _____ Date of last knockout (month, day, year): _____

Longest duration of unconsciousness: _____

Ever knocked unconscious in other sport or in any other way? yes no

If yes, explain: _____

6. Have you ever sustained any neck, spinal or other injury or have any other information concerning your health, past or present, which is not covered by the previous questions? yes no If yes, please explain.

Amateur Boxing Record Wins _____ Losses _____ Draws _____

Professional Boxing Record Wins _____ Losses _____ Draws _____

Amateur Unarmed Combat Record Wins _____ Losses _____ Draws _____

Professional Unarmed Combat Record Wins _____ Losses _____ Draws _____

AFFIRMATION (to be completed by contestant)

I hereby swear or affirm, under penalty of perjury, that the statements made in this report are true, complete and correct; further I realize that any intentional misrepresentation may result in disciplinary action against my license.

Print Name

Signature

Date

**PHYSICAL EXAMINATION
TO BE COMPLETED BY THE DOCTOR ONLY**

GENERAL APPEARANCE	HEIGHT	WEIGHT	TEMPERATURE
OCTOLOGIC		NOSE	
External Trauma <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Perforated Drum <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
OROPHARYNX		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Loose Teeth <input type="checkbox"/> Yes <input type="checkbox"/> No			ADENOPATHY
Tonsils <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			<input type="checkbox"/> Yes <input type="checkbox"/> No
FACE		TESTES	
Recent Trauma <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Jaw and Temporomandibular Joints <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			LUNGS (RALES)
			<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
ABDOMEN		ENLARGED GLANDS	
Enlargement of Liver <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	GOITER
Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Enlargement of Spleen <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Femoral <input type="checkbox"/> Iguinal <input type="checkbox"/> Ventral	
CARDIOVASCULAR			
Blood Pressure (supine) _____	(upright)	_____	
Blood Pressure after 100 hops _____	Blood Pressure 2 minutes later	_____	
Heart Rate (supine) _____	(after two minutes exercise)	_____	
HEART			
Pulse Rhythm <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Apical Impulse <input type="checkbox"/> Heavy <input type="checkbox"/> Normal	
Enlargement <input type="checkbox"/> Yes <input type="checkbox"/> No		Murmurs <input type="checkbox"/> Yes <input type="checkbox"/> No	
BREAST (FEMALE CONTESTANTS)			
Mass <input type="checkbox"/> Yes <input type="checkbox"/> No	Tenderness <input type="checkbox"/> Yes <input type="checkbox"/> No	Discharge <input type="checkbox"/> Yes <input type="checkbox"/> No	
GYNECOLOGICAL EXAM (FEMALE CONTESTANTS)			
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			
MUSCULOSKELETEL			
Hands <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Comments:	_____	
Wrists <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Comments:	_____	
Elbows <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Comments:	_____	
Shoulder Girdle <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Comments:	_____	
Lower Extremities <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Comments:	_____	
REFLEXES			
Pupils _____	Romberg _____	Knee Jerks _____	Babinski _____
NEUROLOGIC			
Mental Status	Orientation _____ /3		
	5-minute recall _____ /3		
Cranial Nerves <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Strength <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
Tone <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Gait <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
Coordination: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			
Finger to Nose <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Tandem Gait <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
COMMENTS OF EXAMINING PHYSICIAN			

I hereby certify that I have examined the named individual and in my opinion, this individual <input type="checkbox"/> is or <input type="checkbox"/> is not medically fit to participate as a contestant in a professional boxing, kick boxing, martial arts or other unarmed combat competition. I also attest that I do not have a professional relationship with, nor financial interest in the earnings of this individual.			
MUST BE COMPLETED AND SIGNED BY M.D. OR D.O.			
PRINT NAME OF EXAMINING PHYSICIAN		PHYSICIANS LICENSE NUMBER	
SIGNATURE OF EXAMINING PHYSICIAN		ADDRESS OF PHYSICIAN	
TELEPHONE NUMBER OF PHYSICIAN		DATE	