



PETE SUAZO
 UTAH ATHLETIC COMMISSION
 LICENSE PHYSICAL EXAMINATION

MUST BE COMPLETED & SIGNED
 BY M.D. or D. O.

PSUAC
 PO Box 146950
 60 East South Temple
 Salt Lake City, UT 84114
 Office: 801-538-8876 FAX: 801-708-0849
 Email: psuac@utah.gov

NAME (LAST, FIRST, MIDDLE)			DATE OF EXAM		
RING NAME (if different)			SOCIAL SECURITY NUMBER		
ADDRESS		CITY	STATE		ZIP CODE
TELEPHONE NUMBER	EMAIL ADDRESS	DATE OF BIRTH	AGE	SEX (Circle) M F	
MEDICAL HISTORY (PLEASE COMPLETE AS THOUGHLY AS POSSIBLE)					
A. HAS APPLICANT EVER HAD ANY OF THE FOLLOWING CONDITIONS, PLACE AN "X" TO ALL THAT APPLY					
<input type="checkbox"/> Fainting Spells <input type="checkbox"/> Rupture (hernia) <input type="checkbox"/> Chest Pain <input type="checkbox"/> Operations <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Rheumatism <input type="checkbox"/> Diabetes <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures/Convulsions <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Spinal Injuries <input type="checkbox"/> Cerebral Hemorrhage or head injury <input type="checkbox"/> Psychiatric problems <input type="checkbox"/> Neck Injuries <input type="checkbox"/> Vision Problems <input type="checkbox"/> Asthma <input type="checkbox"/> Allergies <input type="checkbox"/> Skin Disease <input type="checkbox"/> Heart Palpitations					
1. HAVE YOU EVER BEEN HOSPITALIZED? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", give nature of problem(s), date(s), locations(s) and attending physicians:					
2. HAVE YOU EVER HAD EYE SURGERY? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", explain:					
3. DO YOU REGULARLY OR OCCASIONALLY TAKE ANY MEDICATIONS? ***NOTE: SOME PRESCRIBED MEDICATIONS MAY BE PROHIBITED, IF "YES" CHECK WITH PSUAC OFFICIAL PRIOR TO CONTEST OR www.USADA.org <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", explain frequency & dose:					
4. Are you allergic to any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", explain:					
4. HAVE YOU BEEN PREVIOUSLY INJURED IN A BOXING/KICKBOXING OR MMA EVENT? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", explain:					
5. LONGEST DURATION OF UNCONSCIOUSNESS:					
6. WHAT IS YOUR RECORD: Wins: _____ Losses: _____ Draws: _____			7. WHAT IS YOUR RECORD IN THE LAST YEAR: Wins: _____ Losses: _____ Draws: _____ Losses by TKO or KO: _____		
8. WHEN WERE YOU LAST GIVEN A MEDICAL SUSPENSION? (Date)			9. WHY WERE YOU GIVEN A MEDICAL SUSPENSION?		
MEDICAL EXAM (TO BE COMPLETED BY THE DOCTOR ONLY)					
HEIGHT:	WEIGHT:	TEMPATURE:	GENERAL APPEARANCE:		
OTOLOGIC External Trauma <input type="checkbox"/> Yes <input type="checkbox"/> No Perforated Drum <input type="checkbox"/> Yes <input type="checkbox"/> No		NOSE Instability <input type="checkbox"/> Yes <input type="checkbox"/> No Recent Trauma <input type="checkbox"/> Yes <input type="checkbox"/> No Obstruction <input type="checkbox"/> Yes <input type="checkbox"/> No			
OROPHARYNX Loose Teeth <input type="checkbox"/> Yes <input type="checkbox"/> No		ADENOPATHY <input type="checkbox"/> Yes <input type="checkbox"/> No			
FACE Recent Trauma <input type="checkbox"/> Yes <input type="checkbox"/> No Jaw & Temporomandibular Joints <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		TESTES <input type="checkbox"/> Yes <input type="checkbox"/> No			
LUNGS (RALES) <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		ENLARGED GLANDS <input type="checkbox"/> Yes <input type="checkbox"/> No		GOITER <input type="checkbox"/> Yes <input type="checkbox"/> No	
ABDOMEN Enlargement of Liver <input type="checkbox"/> Yes <input type="checkbox"/> No Hernia <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"/> Inguinal <input type="checkbox"/> Ventral					
HEART Pulse Rhythm <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Apical Impulse <input type="checkbox"/> Heavy <input type="checkbox"/> Normal Enlargement <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Murmurs <input type="checkbox"/> Yes <input type="checkbox"/> No					
MUSCULOSKELETAL 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: _____					



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MEDICAL EXAM CONTINUED (TO BE COMPLETED BY THE DOCTOR ONLY)

(CIRCLE) n/a	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
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(CIRCLE) n/a	GYNECOLOGICAL EXAM (FEMALE CONTESTANTS) <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	NOTES:
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REFLEXES
Pupils _____ Romberg _____ Knee Jerks _____ Babinski _____

NEUROLOGIC

Mental Status Orientation _____ /3
5-minute recall _____ /3

Cranial Nerves Normal Abnormal Strength Normal Abnormal
Tone Normal Abnormal Gait Normal Abnormal
Coordination Normal Abnormal
Finger to Nose Normal Abnormal Tandem Gait Normal Abnormal

PHYSICAL EXAMINATION

Disabling scars _____ Mouth Teeth Tonsils Neck _____
Pulse at rest Blood pressure at rest _____
Pulse after 100 hops Blood pressure after 100 hops _____
Blood pressure 2 minutes later _____

COMMENTS OF EXAMINING PHYSICIAN

I hereby certify that I have examined the named individual and in my opinion, this individual is or 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

I hereby authorize the Pete Suazo Utah Athletic Commission to release, disclose and furnish to any other boxing or athletic commission affiliated with the Association of Boxing Commissions, (ABC), any and all of my medical records concerning my licensure as a participant including, but not limited to, all required medical examinations, laboratory test results for HIV, hepatitis virus and drug screening, hospital records, and the other information regarding conditions related to the propriety my licensure as a participant (Including history, findings, diagnosis, or prognosis).

I understand, and it is agreed, that the signing of the Medical Information Release is optional, and that my declining to sign the document will not result in any adverse action being taken against me by the Pete Suazo Utah Athletic Commission based on my decision. I understand, and it is agreed, that the medical record described herein will not be released for any purpose other than for a member commission affiliated the ABC to determine eligibility to participate in any professional or amateur Boxing, Kickboxing, or Mixed Martial Arts events. I understand, and it is agreed, that this authorization shall remain in effect for 18 months from the date of examination and is relevant medical records described herein, whether such record were created prior to, or subsequent to, the date the authorization is signed. By signing below, I hereby authorize the release of my medical information.

PRINT CONTESTANT NAME	CONTESTANT SIGNATURE	DATE
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