CALIFORNIA AMATEUR MIXED MARTIAL ARTS ORGANIZATION, INC.
P.O. Box 4641 Riverside, CA 92514
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AMATEUR ATHLETE PHYSICAL EXAMINATION

APPLICANT NAME RING NAME TELEPHONE DATE OF BIRTH

ADDRESS CITY STATE ZIP CODE COUNTRY

PHYSICAL HISTORY: Have you ever had any of the following conditions:
□ 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 None
No. of knockout losses in your career _____ Date of last knockout _____
Have you ever suffered a loss of consciousness for any reason? YES NO
If so, please explain and provide date(s) and location(s):
_____
When was the last time you took any type of medication or drug? (State what type and when)
_____
Have you ever undergone any type of surgery? □ Yes □ No If so, please describe.
_____
When was the last time you took any type of vitamin supplement? (State what type and when)
_____
Amateur record: Wins _____ Losses _____ Draws _____
Professional boxing/kickboxing: Wins _____ Losses _____ Draws _____
Additional information: _____
_____

PHYSICAL EXAMINATION:
General appearance: _____ Height: _____ Weight: _____ Temperature: _____
Disabling scars: _____ Mouth: _____ Teeth: _____ Tonsils: _____ Neck: _____
Pulse at rest: _____ Pulse after 100 hops: _____
Blood pressure: At rest: _____ After 100 hops: _____ 2 minutes later: _____
Enlarged glands: □ Yes No -- Goiter: Yes No
Heart: Pulse rhythm Regular Irregular – Murmurs: Yes No
Apical impulse: Heavy Normal - Enlargement: Yes No
Lungs: Rales Yes No - Abdomen: Enlargement of liver Yes No
Breasts: Mass Yes No – Tenderness Yes No – Discharge Yes No
Enlargement of Spleen: Yes No – Hernia: Yes No
Femoral Inguinal Ventral – Testicles: Normal Yes No
Remarks:_____
Reflexes: Pupils _____ Knee jerks _____ Romberg _____
Babinski _____ Skin: Tone _____ Rash _____Boils _____Other:_____

Unhealed wounds:_____
Remarks:_____

EYE HISTORY: Have you ever had any of the following conditions:
Blurred vision? □ **Yes No** – If YES, please explain in full: _____
_____

Have you ever had any surgical procedures done to your eye(s) or the tissues around your eye(s) other than simple sutures of the skin around the eye? □ **Yes No** – If YES, please explain in full: _____
_____

Have you ever been diagnosed by a physician to have significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, or dislocated lens? **Yes No** – If YES, please explain in full:
_____
_____

EXAMINING PHYSICIAN:
I have examined the above named applicant and **I DO NOT FIND** a condition that would preclude him/her from being licensed as amateur mixed martial arts athlete.

Authorization for release of medical information is attached.

_____ _____
***LICENSED PHYSICIAN'S NAME (print)** ***MEDICAL LICENSE NUMBER**

_____
ADDRESS **CITY** **STATE** **ZIP CODE**

_____ _____
TELEPHONE NUMBER **DATE/TIME**

_____
PHYSICIAN'S SIGNATURE

*Must be a licensed physician (MD or DO ONLY). No physician assistant (PA) or nurse (NP) signatures accepted without accompanying physician name, signature, and medical license number.

**Please note: Athletes who are 40 years of age or older must also undergo an EKG test and provide CAMO with results and doctor's signoff showing proper fitness for competition.