CALIFORNIA AMATEUR MIXED MARTIAL ARTS ORGANIZATION, INC.
INTERNET: www.camomma.org
MEDICAL SUBMISSIONS: medicals@camomma.org
QUERIES: info@camomma.org
FAX: (888) 663-9915

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?:

☐ None

☐ 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:_____

Number of knockout losses in your career: _____ Date of last knockout: _____

Have you ever suffered a loss of consciousness for any reason?: ☐ NO ☐ YES

If YES, 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? ☐ **No** ☐ **Yes** If YES, please describe (State what type and when):

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 (ALL FIELDS REQUIRED):

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: _____

Heart Pulse Rhythm:	☐ Regular	☐ Irregular	Lungs: Rales	☐ No	☐ Yes
Murmurs:	☐ No	☐ Yes	Goiter:	☐ No	☐ Yes
Apical impulse:	☐ Normal	☐ Heavy	Enlarged glands:	☐ No	☐ Yes
Enlargement:	☐ No	☐ Yes	Testicles: Normal	☐ Yes	☐ No
Breasts: Tenderness	☐ No	☐ Yes	Hernia:	☐ No	☐ Yes
Breasts: Mass	☐ No	☐ Yes	Abdomen: Enlargement of liver	☐ No	☐ Yes
Breasts: Discharge	☐ No	☐ Yes	Enlargement of Spleen:	☐ No	☐ Yes

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? □ **No** □ **Yes** – 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? □ **No** □ **Yes** – 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? □ **No** □ **Yes** – 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 **APPOINTMENT DATE/TIME** (Form incomplete if left blank)

_____
PHYSICIAN'S SIGNATURE (MD or DO ONLY*)

*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 complete the separate **ATHLETE 40+ MEDICAL PACKET** in full.

Submission Instructions:

Submit completed medicals to **1-888-663-9915** or e-mail to **medicals@camomma.org** for processing. Ensure **ALL** fields are completed with the physician in full prior to submission or the submission will be denied. Medicals will be forwarded to and processed by *Pro-Am Sports Medicine*.