



CALIFORNIA AMATEUR MIXED MARTIAL ARTS ORGANIZATION, INC  
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## CARDIOVASCULAR HISTORY and EKG REPORT

***Only a licensed physician may conduct  
Physical and EKG examinations and complete this form.  
Please complete this form in its entirety.***

**This Cardiovascular History shall include a current EKG report performed with the past thirty (30) days.**

This examination does not take the place of any other examination required by CAMO. It also does not take the place of any general physical examination, diagnosis, or medical treatment of the applicant. It is solely for the purpose of aiding CAMO in determining whether the applicant's present *cardiac condition* permits him or her to be licensed for competition.

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Name of Applicant (Print Name) \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Date of EKG Report:** \_\_\_\_\_

**Date of this Report:** \_\_\_\_\_

Do you get tired more quickly than your friends do during exercise? **Yes No** If YES, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever had racing of your heart or skipped heartbeats? **Yes No** If YES, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you been told you had high blood pressure or high cholesterol? **Yes No** If YES, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever been told you have a heart murmur? **Yes No** If YES, please explain: \_\_\_\_\_

\_\_\_\_\_

Has any family member or relative died of heart problems or of sudden death before age 50? **Yes No** If YES, please explain: \_\_\_\_\_

\_\_\_\_\_

# CARDIOVASCULAR HISTORY

APPLICANT NAME: \_\_\_\_\_

Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the past month? **Yes No** If YES, please explain: \_\_\_\_\_

Has a physician ever denied or restricted your participation in sports for any heart problems? **Yes No** If YES, please explain: \_\_\_\_\_

Does the athlete have Normal Sinus Rhythm? **Yes No** If NO, please explain: \_\_\_\_\_

Is the EKG within normal limits? **Yes No** If NO, please explain: \_\_\_\_\_

Based on your personal medical opinion and considering Commission rules, is this applicant cardiologically eligible to be licensed to compete and participate in combative sports? **Yes No** If NO, please explain:

Is further referral or additional examinations necessary or recommended? **Yes No** If YES, please explain: \_\_\_\_\_

EXAMINING PHYSICIAN:

\_\_\_\_\_  
\*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.