WASHINGTON STATE DEPARTMENT OF LICENSING

Physical Examination for Amateur Mixed Martial Arts Participant

[redacted]

Patient fill out this page before seeing the licensed medical doctor.
Give this form packet to your licensed medical doctor.

PRINT or TYPE Name			
Address *(Address, City, State, ZIP code)*			
(Area code) Phone number	Date of birth	Age	Exam date

21040-APPLICATIONS

Medical History

Medicines and allergies

List all prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? ☐ Yes ☐ No

If yes, identify specific allergy: ☐ Medicines _____ ☐ Pollens _____ ☐ Food _____ ☐ Stinging insects _____

General questions	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have any ongoing medical conditions?	☐	☐
If yes, identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections ☐ Other _____		
3. Have you ever spent the night in a hospital?	☐	☐
4. Have you ever had surgery?	☐	☐

Heart health questions about you	Yes	No
5. Have you passed out or nearly passed out DURING or AFTER exercise?	☐	☐
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐
7. Does your heart ever race or skip beats (irregular beats) during exercise?	☐	☐
8. Has a doctor ever told you that you have any heart problems?	☐	☐
If yes, check all that apply: ☐ High cholesterol ☐ High blood pressure ☐ Heart murmur ☐ Heart infection ☐ Kawasaki disease ☐ Other _____		
9. Has a doctor ever ordered a test for your heart? (ECG/EKG, echocardiogram)	☐	☐
10. Do you get lightheaded or feel more short of breath than expected during exercise?	☐	☐
11. Have you ever had an unexplained seizure?	☐	☐
12. Do you get more tired or short of breath more quickly than your friends during exercise?	☐	☐

Heart health questions about your family	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?	☐	☐
14. Does anyone in your family have Marfan syndrome, hypertrophic cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy, long or short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic, ventricular trachycardia?	☐	☐
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrilator?	☐	☐
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	☐	☐

Bone and joint questions	Yes	No
17. Have you had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?	☐	☐
18. Have you had any broken or fractured bones or dislocated joints?	☐	☐
19. Have you had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, cast, or crutches?	☐	☐
20. Have you had a stress fracture?	☐	☐
21. Have you been told you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)	☐	☐
22. Do you regularly use a brace, orthotics, or other assistive device?	☐	☐
23. Do you have a bone, muscle, or joint injury that bothers you?	☐	☐
24. Do any of your joints become painful, swollen, feel warm, or look red?	☐	☐
25. Do you have any history of juvenile arthritis or connective tissue disease?	☐	☐

Medical questions	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
27. Have you ever used an inhaler or taken asthma medicine?	☐	☐
28. Is there anyone in your family who has asthma?	☐	☐
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	☐	☐
30. Do you have groin pain or a painful bulge or hernia in the groin area?	☐	☐
31. Have you had infectious mononucleosis within the last month?	☐	☐
32. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
33. Have you had a herpes or MRSA skin infection?	☐	☐
34. Have you had a head injury or concussion?	☐	☐
35. Have you had a hit or blow to the head that cause confusion, prolonged headache, or memory problems?	☐	☐
36. Do you have a history of seizure disorder?	☐	☐
37. Do you have headaches with exercise?	☐	☐
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
39. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
40. Have you ever become ill while exercising in the heat?	☐	☐
41. Do you get frequent muscle cramps when exercising?	☐	☐
42. Do you or someone in your family have sickle cell trail or disease?	☐	☐
43. Have you had any problems with your eyes or vision?	☐	☐
44. Have you had any eye injuries?	☐	☐
45. Do you wear glasses or contact lenses?	☐	☐
46. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
47. Do you worry about your weight?	☐	☐
48. Are you trying to or has anyone recommended that you gain or lose weight?	☐	☐
49. Are you on a special diet or do you avoid certain types of foods?	☐	☐
50. Have you ever had an eating disorder?	☐	☐
51. Do you have any concerns that you would like to discuss with a doctor?	☐	☐

Females only	Yes	No
52. Have you had a menstrual period?	☐	☐
53. How old were you when you had your first menstrual period? _____		
54. How many periods have you had in the last 12 months? _____		

Explain "yes" answers here:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

X Patient signs and dates here.

Signature of patient Date

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This page must be completed and signed by a licensed M.D., D.O, or N.D.

Attach this page to your application or email to: dolcombativesports@dol.wa.gov. For questions, call (360) 664-6644.

PRINT or TYPE Name					Date of birth
Address *(Address, City, State, ZIP code)*					(Area code) Phone number
Height	Weight	Blood pressure /	Pulse	Vision R 20/ L 20/	Corrected ☐ Yes ☐ No

Medical	**Normal**	**Abnormal findings**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachmodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)	☐ Yes ☐ No	
Eyes/ears/nose/throat • Pupils equal • Hearing	☐ Yes ☐ No	
Lymph nodes	☐ Yes ☐ No	
Heart (consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam) • Murmurs (ausculation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)	☐ Yes ☐ No	
Pulses • Simultaneous femoral and radial pulses	☐ Yes ☐ No	
Lungs	☐ Yes ☐ No	
Abdomen	☐ Yes ☐ No	
Genitourinary (males only) (consider GU exam if in private setting; having third party present is recommended)	☐ Yes ☐ No	
Skin • HSV, lesions suggestive of MRSA, tinea corporis	☐ Yes ☐ No	
Neurologic (consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion)	☐ Yes ☐ No	
Musculoskeletal	**Normal**	**Abnormal findings**
Neck	☐ Yes ☐ No	
Back	☐ Yes ☐ No	
Shoulder/arm	☐ Yes ☐ No	
Elbow/forearm	☐ Yes ☐ No	
Wrist/hand/fingers	☐ Yes ☐ No	
Hip/thigh	☐ Yes ☐ No	
Knee	☐ Yes ☐ No	
Leg/ankle	☐ Yes ☐ No	
Foot/toes	☐ Yes ☐ No	
Functional • Duck-walk, single leg hop	☐ Yes ☐ No	

☐ Cleared for all sports without restriction

☐ Not cleared

☐ Pending further evaluation ☐ For any sports ☐ For certain sports: _____

Reason: _____

Recommendations: _____

I have examined the above-named individual and completed the Physical Examination. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above.

PRINT or TYPE Licensed medical doctor name **(M.D., D.O., or N.D. ONLY)**	(Area code) Phone number
Medical license number	Jurisdiction
Address *(Address, City, State, ZIP code)*	

TYPE or PRINT Name of licensed medical doctor

X **Licensed medical doctor signs and dates here.**

Licensed medical doctor signature **(M.D., D.O., or N.D. ONLY)** Date