

## OFFICE OF COMBATIVE SPORTS

## PHYSICAL AND NEUROLOGICAL EXAMINATION

Only a licensed medical doctor or physician's assistant may conduct this examination and complete this form. The exam must be completed in person, as exams administered virtually are not accepted.

## **APPLICANT INFORMATION**

Last name		First name	Mi	Middle name		Date of birth	
PHYSIC	CAL INFORMATION	Your <b>physicia</b>	<b>n</b> must complete the	remainder of this form in i	ts entirety.		
Height:	: Weight:	Temp:	Afebrile RR	:BP:	HR	·	
		Normal	Abnormal		Normal	Abnormal	
Genera	I		Abd.	(Hernias)			
HEENT	Head			(Masses/tenderness)			
	PERRLA/EOMI		Ext.	Extremities			
	Periorbital regions			Hands/wrists			
	Ears/hearing (grossly)			Knuckle push-ups			
	Jaw/oropharynx/teeth			Duck/crab walk			
	Nose (stability, etc)		Skin	(Rashes/lacerations)			
	Lymph nodes		Neuro.	Alertness/orientation			
	Neck			Cranial nerves (grossly)			
Vision	PERRLA/EOMI			Tandem gait			
	Peripheral/fields (grossly			Romberg/pronator drift			
leart	Rhythm/sounds/murmur	S		Finger to nose			
hest	Lungs			Reflexes			
	Ribs		Other:				
Abnorn	nalities:						
his in	•	fit to be lic	ensed and compe	exam results, is it your te in combative sports			
Physici	an's name	Si	gnature	License num	nber D	ate	
 Email			one	Clinic/Hospi			