MOHEGAN TRIBE
DEPARTMENT OF ATHLETIC REGULATION

PHYSICAL EXAMINATION FORM

Name: ________________________________ DOB:_____/_____/_____ Date of Exam:____/_____/_____

Fighter Complaints: ____

____

____

____

Visual Acuity: OD _____ OS _____ OU _____ Audiometry dbl: 20( ) 25 ( ) 40 ( )

(With glasses/contacts) OD _____ OS _____ OU _____

Near Vision: OD _____ OS _____ OU _____

Hz	500	1000	2000	4000

Height: ___________ Weight: ___________ Weight Class: ____________________________________

UA: S.G. ______ Protein _______ Blood _______ Glucose _______ Nitrite _______ Leuk _______ Billi _______

Medications: 1) ________________________ 2) ________________________ 3) ________________________
4) ________________________ 5) ________________________ 6) ________________________
7) ________________________ 8) ________________________ 9) ________________________

SYSTEM REVIEW: (check if abnormal)

Constitutional:
- ☐ Fevers
- ☐ Chills
- ☐ Sweats
- ☐ Excessive Thirst
- ☐ Fatigue/Change in Energy

Skin:
- Rash
- Moles ☐
- ☐Flushing ☐
- ☐Dry Skin
- ☐Lesions
- ☐Bruising
- ☐Lumps

Head/Eyes:
- Change in Vision
- Hair loss
- Puritis

Ears/Nose/Throat/Neck:
- Difficulty Hearing
- Ringing in Ears ☐
- Congestion
- Gun/Teeth Problems
- Swallowing Difficulties
- Hay Fever/Allergies
- Swollen Nodes
- Stiffness
- Sinus Pain

Heart:
- ☐ Palpitations
- ☐ Chest Pains
- ☐ Rapid Rate
- ☐ Fainting
- ☐ Edema

Lungs:
- ☐Shortness of Breath
- ☐Wheezing
- ☐Cough
- ☐Exertional Dyspnea
- ☐Orthopnea

Chest Wall:
- ☐ Pain
- ☐ Lumps
- ☐ Nipple Discharge
- ☐ Rib Strain

GI:
- ☐ Abdominal Pain
- ☐ Change in Appetite
- ☐ Constipation
- ☐ Diarrhea
- ☐ Change in Bowel Habits
- ☐ Blood in Stool
- ☐ Hemorrhoids
- ☐ N/V
- ☐ Weight Loss
- ☐ Weight Gain
- GERD
- ☐ Dysphasia

GU:
- ☐ Frequent Urination
- ☐ Nighttime Urination
- ☐ Leakage
- ☐ Burning/Urgency
- ☐ Discharge
- ☐ Sexual Dysfunction

Bone/Joint:
- ☐Muscle Pains
- ☐Cramps
- ☐Spasms
- ☐Restless Leg
- ☐Weakness
- ☐Back Pain

CNS/Psych:
- ☐ Headache
- ☐ Dizziness
- ☐ Memory Loss
- ☐ Numbness
- ☐ Change in Coordination
- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia
- ☐ Tremor
- ☐ Vertigo

Extremity:
- ☐ Swelling
- ☐ Fungus
- ☐ Varicosities

Other: (list)
- ☐
- ☐
- ☐
- ☐

Name:________________________________

PHYSICAL EXAMINATION FORM

Vital Signs: B/P ________/________ PULSE ________ RESP. ________ TEMP ________

HEENT:	nl./neg.	Abn.	Comments:
PERL/EOMI	☐	☐	____________
TM	☐	☐	____________
Turbinates	☐	☐	____________
Throat	☐	☐	____________
Nodes	☐	☐	____________
Bruits	☐	☐	____________
Thyroid	☐	☐	____________
JVD	☐	☐	____________
Axillary Nodes		☐☐	____________
Nystagmus	☐	☐	____________
Lungs:			
CTA	☐	☐	____________
Heart:			
Rate	☐	☐	____________
Rhythm		☐	____________
M/G/R	☐	☐	____________
Ectopy	☐	☐	____________
Abdomen:			
Soft	☐	☐	____________
NT	☐	☐	____________
ND	☐	☐	____________
Masses	☐	☐	____________
Organomegaly		☐	____________
Hernia	☐	☐	____________
Weight	☐	☐	____________
Skin:			
Lesions/Herpes		☐	____________
Rash	☐	☐	____________
Alopecia	☐	☐	____________
Scars/Tatoos	☐	☐	____________

Back:	nl/neg.	Abn.	Comments:
Curvature	☐	☐	____________
CVA Tenderness	☐		____________
Chest/Breast:			
Masses	☐	☐	____________
Dimpling	☐	☐	____________
Discharge	☐	☐	____________
Deferred	☐		____________
Genitalia:			
External	☐	☐	____________
Testicular Mass	☐		____________
Hernia	☐	☐	____________
Lesions	☐	☐	____________
Rectal	☐	☐	____________
Deferred	☐		____________
Pelvic:			
Masses	☐	☐	____________
Lesions	☐	☐	____________
Ovaries:	☐	☐	____________
Cervix	☐	☐	____________
Deferred/NA			____________
Ext./Mus/Skel:			
C/C/E	☐	☐	____________
Onychomycosis	☐		____________
Varicose Veins	☐☐		____________
Pulses	☐	☐	____________
Joints	☐	☐	____________
Muscles	☐	☐	____________
Neuro:	☐	☐	____________
Appearance	☐	☐	____________

Tests: (Complete if Results Available)

EKG:	☐	☐	Date: ____________
HIV:	☐	☐	Date: ____________
HepBsAg	☐	☐	Date: ____________
HepC Ab	☐	☐	Date ____________
CT Brain		☐	Date: ____________
MRI Brain		☐	Date: ____________

Comments: ____

____

____

The above fighter is: ________ is NOT: ________ medically cleared to participate
(Must be signed by an MD/DO)
Physician Name (Print): ____________________________, MD/DO Signature:____________________

Address:____

City: ________________________ State: ________ Zip: __________ Date of Examination:________________

MOHEGAN TRIBE
DEPARTMENT OF ATHLETIC REGULATION
MEDICAL HISTORY FORM

Name: ____ Federal ID #: ____________________________

Address: ______________________________________ Date of Birth: ________/________/________

City:_______________ _________________________ State: ____________ Country: _______________

Telephone #: (   ) ____________________________ E-mail:__________________________________

Professional Fight Record: W _____ L _____ D _____ Date of Last Fight: _______/________/________

If you answer **yes** to any of the following questions, please explain in the space provided below.

1) Do you have any medical problems? Yes ( ) No ( )

2) Do you take any medications on a regular basis? Yes ( ) No ( )

3) Have you taken any medications for any purpose over the past 2 weeks? Yes ( ) No ( )

4) Have you ever been stopped or knocked out? Yes ( ) No ( ) *If* ***yes****, please list date:* ______/______/_____

5) Did anyone in your immediate family die from a heart problem before age 40? Yes ( ) No ( )

6) Do you have any injuries which may affect your ability to fight? Yes ( ) No ( )

7) Did you injure yourself while training for this fight? Yes ( ) No ( )

8) Do you wear protective equipment while fighting? (for example-a knee brace) Yes ( ) No ( )

9) Have you ever had surgery? (including eye or musculoskeletal) Yes ( ) No ( )

10) Are you taking any vitamins, sport supplements, or herbal medications? Yes ( ) No ( )

11) Do you ever have any of the following?

a) Frequent Headaches?	Yes	( )	No	( )
b) Dizziness or Fainting?	Yes	( )	No	( )
c) Seizures?	Yes	( )	No	( )
d) Chest Pains?	Yes	( )	No	( )
e) Shortness of Breath?	Yes	( )	No	( )
f) Heart Murmur?	Yes	( )	No	( )
g) Asthma?	Yes	( )	No	( )

12) How much weight did you lose leading up to this fight? ____________________

Please explain all **yes** answers in space below:

I have answered the above questions truthfully and to the best of my knowledge. I know that purposely providing misinformation can result in disciplinary action, loss of my Federal ID #, and fines or suspensions.

Boxer Signature: ______________________**Witness:** ______________________ **Date:**______/______/______