MINNESOTA

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 Middle name		Date of birth		
PHYSIC	CAL INFORMATION	Your physicia	n must complete the	remainder of this form in i	ts entirety.	
Height:	Weight:	Temp:	Afebrile RR	:: BP:/	HR	:
		Normal	Abnormal		Normal	Abnormal
General			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		
Heart	Rhythm/sounds/murmu	rs		Finger to nose		
Chest	Lungs			Reflexes		
	Ribs		Other:			
Abnorm	nalities:					
				exam results, is it your		
				te in combative sports	s? <mark>YE</mark>	s <mark>NO</mark>
If no, p	lease explain:					
Physicia	an's name	Si	gnature	License num	nber D	oate
 Email		 Ph	one	Clinic/Hospi	tal	