GAMMA
GLOBAL ASSOCIATION OF MIXED MARTIAL ARTS

THREE PILLAR PROMOTIONS

Comprehensive Amateur Physical Examination Report

Front To be Completed by Fighter

Attention Fighter:

Listed below are the requirements for fighters on all GAMMA -sanctioned cards.
Please print your physical form and this cover letter and take them to your physician:

Fighter physical: have the "Health History" section of this form completed before going to your doctor's office. Physicals missing this portion filled out by the fighter will not be accepted. The second page of this document is for your doctor to fill out.

Blood work: you must have the following three blood work tests with negative results:

HIV (oral swab will not be accepted)
Hepatitis B Surface Antigen
Hepatitis C Antibody

Other tests, such as Hepatitis B Surface Antibody or Hepatitis B Envelope Antigen are NOT sufficient. ALL fighters must have this test, regardless of whether or not they have been immunized.

give this form to your doctor to ensure they order the correct blood work tests

If you have any questions, please do not hesitate to reach out to: threepillarpromotions@gmail.com

Thank you! - Three Pillars

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Front To be Completed by Fighter

Legal Name:_____

Address:_____
Street City State Country

Telephone: _____ E-mail: _____ Date of Birth: _____

Sex: □ M □ F Emergency Contact:_____ Emergency Telephone:_____

Health History

Do you have or have you ever had any of the following?

	Yes	No		Yes	No
Seizure, flashing lights	□	□	High blood pressure	□	□
Headaches or dizziness	□	□	Asthma or wheezing	□	□
Cerebral hemorrhage	□	□	Broken bones or recent sprains	□	□
Passed out during exercise	□	□	Neck or spine injury	□	□
Double or blurred vision	□	□	Hernia	□	□
LASIK, PRK, or other eye surgery	□	□	Cold sores, fever blisters or herpes	□	□
Retinal Detachment	□	□	Diabetes	□	□
Hearing difficulty	□	□	Bleeding problems	□	□
Broken nose	□	□	Hepatitis or liver problems	□	□
Chest pain	□	□	Heat stroke/heat exhaustion	□	□
Irregular heart beat or murmur	□	□	Recent illness or fever	□	□
Muscle cramping during exercise	□	□	Sickle cell trait or disease	□	□

If "Yes" to any of the above, explain: _____

	Yes	No	
Have you ever had a concussion, a head injury, or lost consciousness?	□	□	_____
Have you ever had suffered a knockout or lost a match by TKO?	□	□	_____
Do you or have you ever used steroids, testosterone, or banned substances?	□	□	_____
Have you ever had any other surgeries?	□	□	_____
Do any diseases run in your family?	□	□	_____
Have you seen a doctor for *any* medical problem in the last 3 months?	□	□	_____
Do you have any other medical conditions or training/sparring injuries?	□	□	_____
Women only: Have you ever had any type of breast surgery?	□	□	_____
Is there any chance you may be pregnant?	□	□	_____

Are you allergic to any medications or supplements? _____
What medications or supplements are you taking on a regular basis? _____
What medications or supplements have you taken within the last two weeks? _____

Sport History

Amateur Record:_____ Pro Record:_____ Number of TKO losses:_____
Date of last bout:_____ Result:_____ Number of times knocked out:_____
Number of times knocked out in past year:_____ Date of last knock out:_____

I hereby authorize the. I certify that I have been training faithfully and am in good physical condition. I attest that the answers given above are true and correct to the best of my knowledge and belief. I understand that the examining physician depends on the reliability of the statements I made above and I am not withholding any information from the examining physician. I further understand that all statements and information supplied by me are made under the penalty of perjury and if untrue and not informative, will lead to penalty and/or suspension.

_____ _____ _____
Name (printed) Signature Date

To be Completed by Physician

Physical Examination for: _____

Height: _____ Weight: _____ Blood Pressure: _____ Temperature: _____ Pulse: _____

General appearance: _____

HEENT: _____

Pupils: Reg _____ Round _____ Equal _____ React Light _____ Accom _____
OD OS Periorbital scars
Acuity _____ _____ _____

Oropharynx: _____

Neck: LA _____ Goiter _____ ROM _____

Lungs: _____

Heart: _____

Abd: _____

Inguinal region: _____

Cervical Spine/Neck: _____

Back: _____

Shoulders: _____

Arm/Elbow/Wrist: _____

Knees: _____

Ankles: _____

Hips: _____

Hands/Feet/Small Joints: _____

Skin: _____

Neuro: _____

Gait: _____ Rhomberg: _____ FNF: _____ RAM: _____

Muscle stretch reflexes: _____ Motor: _____ Sensory: _____

Orientation: Self, time, place: _____

Mental assessment: _____

Contestant is physically and mentally fit to fight in a Combative Martial Arts competition. O Yes O No

Physician's Signature: _____ Date of Exam: _____/_____/_____
Physician's Name: _____ Practice/Company (if applicable): _____
Physician License Number: _____ State of License: _____
Street Address: _____ City _____ State: _____ Zip: _____
Phone :( ) _____