IKF FIGHTER PRE-BOUT PHYSICAL FORM

FIRST _____ **BOUT #:** _____

LAST _____

AGE ____ **Birthday (Mo, Day & Year):** ____ / ____ / ____ **M** ____ **F** ____ **CORNER:** _____

FIGHTER: Please Answer ALL Of The Following Questions Before Your Fighter Physical Check Below.

PLEASE CHECK YES or NO At Right To The Following Questions	YES	NO
Do you have medical insurance?	_____	_____
Any chronic medical conditions? (Diabetes, asthma, heart condition etc.)	_____	_____
If chronic medical conditions Please Explain:		
Ever had any surgery	_____	_____
If Had Surgery Please Explain:		
Ever been Hospitalized?	_____	_____
If Hospitalized Please Explain:		
Ever had a fracture or dislocation? If yes, when? **M:**_____ **D:**_____ **YR:**____	_____	_____
Ever a sprain or strain requiring special equip or braces? If yes, when? ___ **/**___/ ____	_____	_____
Any vision problems?	_____	_____
Do you wear contact lenses?	_____	_____
Ever passed out while exercising? If yes, when? **M:**_____ **D:**_____ **YR:**____	_____	_____
Ever had chest pains while exercising? If yes, when? **M:**___ **D:**____ **YR:**___	_____	_____
Ever felt dizzy while exercising? If yes, when? **M:**_____ **D:**_____ **YR:**____	_____	_____
Ever had wheezing or coughing while exercising? If yes, when? **M:**____ **D:**___ **YR:**___	_____	_____
Ever been told you have high blood pressure?	_____	_____
Ever feel as though your heart is skipping beats or have runs of irregular rhythm?	_____	_____
Ever been told you have a heart murmur?	_____	_____
Any family members die suddenly before the age of 50?	_____	_____
Any congenital defect such as single kidney, undescended testicle, cardiac defect?	_____	_____
Do you have any hernias, groin or abdominal?	_____	_____
Ever had a head injury or concussion? If yes, When? M:____ **D:**___ **YR:**___	_____	_____
Ever been knocked unconscious? If yes, When? M:____ **D:**____ **YR:**___	_____	_____
Ever had a pinched nerve or numbness or tingling in your arms, hands or feet?	_____	_____
Ever had a heat stroke? If yes, when? **M:**_____ **D:**_____ **YR:**____	_____	_____
Do you have any drug allergies? If yes, what:	_____	_____
WOMEN: You may be asked to take a pregnancy test. ARE YOU PREGNANT?	_____	_____

Fighters Signature: _____ **Date:** ____/____/_____

MEDICAL QUESTIONS: Doctor (MD / DO) Only Below This Line

Physical Check	RESULT		Physical Check	RESULT
TIME OF PHYSICAL	_____	_____	Fighters Eyes	_____
Fighters Age	_____	**BOOKED WEIGHT**	Fighters Heart	_____
Fighters Pulse	_____		Fighters Lungs	_____
Fighters Blood Pressure	_____	_____	Fighters Hernia/Abd.	_____
Fighters Hands	_____	**WEIGH-IN WEIGHT**	Physical Look	_____

Doctor Signature: _____ **Print Name:** _____ **Date:** ____/____/_____