IKF FIGHTER FULL PHYSICAL EXAMINATION

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ONLY A LICENSED PHYSICIAN (MD OR DO) MAY CONDUCT THIS EXAMINATION AND COMPLETE THIS FORM IN ITS ENTIRETY NO MORE THEN 30 DAYS PRIOR TO BOUT.

1: FIGHTER'S FIRST NAME ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

2: FIGHTER'S LAST NAME ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

3: AGE ☐☐ Birthday (Month, Day & Year): ☐☐ / ☐☐ / ☐☐ ☐ **MALE** ☐ **FEMALE**

PLEASE Answer the following questions. Explain any "YES" response in full.

4 - Have you ever had blurred vision? ___ Yes ___ No _____

5 - Have you ever had any surgical procedures done to your eye(s) or the tissues around your eye(s) other than simple sutures of the skin around the eye? ___ Yes ___ No _____

6 - Have you ever been diagnosed by a physician to have significant eye problems such as, but not limited to, blindness in either eye, retinal tear, retinal detachment, primary or secondary glaucoma, aphakia, pseudophakia, or dislocated lens? __Yes ___No

7 - Do you have any groin pain, bulging or history of a hernia? ___Yes ___No _____

8 - Do you presently have any open cuts, sores, wounds, or rashes? ___Yes ___No _____

9 - When was the last time you took any type of medication or drug? (*State what type and when and be specific*):

10 - Have you ever undergone any type of surgery? ___ Yes ___ No (*State what type and when and be specific*)

11 - When was the last time you took any type of vitamin supplement? (*State what type and when and be specific*)

12 - PHYSICAL HISTORY: PLEASE CHECK ALL THAT APPLIES BELOW:

___Asthma ___Blood in urine ____Allergies ___Fainting spells ___Rupture (hernia) ___Chest pains ___Operations ___Diabetes ___ Hypertension ____ Abnormal Bleeding ___Shortness of breath ___Swollen joints ___Frequent headaches ___Convulsions (fits) ___Chronic cough ___Cerebral hemorrhage or serious head injury. IF ANY CHECKED, EXPLAIN ON BACK>

13: WOMEN: Are you Pregnant? _____ You may be asked to take a pregnancy test prior to your bout.

14: FIGHTER'S SIGNATURE _____ *OR PARENT IF MINOR UNDER 18*

PHYSICAL EXAMINATION - BY MD OR DO ONLY

General Appearance: ____ Healthy ____ Other (Explain) _____ Height _____ Weight _____

PULSE: Resting _____ AFTER EXERCISE _____

BP: Resting_____ AFTER EXERCISE _____ 2 Min Later _____ Febrile? ____Yes ___No

	Normal?	YES	NO		YES	NO		YES	NO
HEENT:	MOUTH	____	____	HEART	____	____	EXTREMITIES	____	____
	TEETH	____	____	CHEST	____	____	NEURO	____	____
	EYES	____	____	LUNGS	____	____	REFLEXES	____	____
	ADENOPATHY	____	____	ABDOMEN	____	____	SKIN	____	____
	THYROID	____	____	JOINTS	____	____	VISUAL FIELDS	____	____

PHYSICIAN TO EXPLAIN ANY ABNORMALITY or "NO" RESPONSE:_____

VISION: Does Fighter Wear Contacts To See? ___Yes ___No

Can Fighter see at least 20/50 At 3 Feet with EACH Eye & BOTH Eyes UNCORRECTED? ____ Yes ____No

If No, What is Vision UNCORRECTED: R: __/__ L: __/__ B: __/__ & CORRECTED: R: __/__ L: __/__ B: ___/___

MANDATORY: EXAMINING DOCTOR MUST ANSWER YES OR NO!

BASED ON YOUR OBSERVATION AND REVIEW, is it your medical opinion that this applicant is physically fit to compete as a Full Contact Kickboxer or Muay Thai Fighter? ___**YES** ___**NO.**

If NO, Please Explain:_____

_____ **MD OR DO?** _____ _____

PRINT NEATLY LICENSED PHYSICIAN'S NAME **MEDICAL LICENSE NUMBER** **OFFICE TELEPHONE NUMBER**

_____ _____ _____ _____

STREET ADDRESS **CITY** **ZIP CODE** **DOCTOR'S SIGNATURE & TITLE!**

FORM MUST HAVE PHYSICIAN'S STAMP

OR MEDICAL CENTER STAMP TO RIGHT ⇨⇨⇨⇨

PHYSICAL EXAM DATE MUST BE WITHIN 30 DAYS OF BOUT.

DO NOT HAVE A PHYSICIANS ASSISTANT OR NURSE DO THIS PHYSICAL!!!

DATE OF EXAM: _____/_____/_____