

2013 IKF WORLD CLASSIC PRE-BOUT PHYSICAL FORM

- Date: July 19th, 20th & 21st, 2013
- Event City: ORLANDO
- Event State: FLORIDA
- Event Country: USA

FIGHTERS FULL NAME _____

AGE: _____ **- DOB:** ____/____/____

FIGHTER: Please answer ALL of the following Questions Before your fighter physical check below

When Was Your Last Bout (IF ANY)? ____/____/____ Result: ____ WIN ____ LOSS ____ DRAW How Did It End: ____ Decision ____ TKO ____ KO ____ DQ ____ INJ.	Ever Been Knocked Unconscious ? If Yes, Last Time? ____/____/____	Ever Had Any Medical Suspension ? If Yes, Last Time? ____/____/____
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 YES to 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? ____/____/____	_____	_____
Ever had a sprain or strain requiring special equip. or braces? If YES , when? ____/____/____	_____	_____
Any vision problems?	_____	_____
Do you wear contact lenses?	_____	_____
Have you ever passed out while exercising? If YES , when? ____/____/____	_____	_____
Have you ever had chest pains while exercising? If YES , when? ____/____/____	_____	_____
Have you ever felt dizzy while exercising? If YES , when? ____/____/____	_____	_____
Have you ever had wheezing or coughing while exercising? If YES , when? ____/____/____	_____	_____
Have you ever been told you have high blood pressure?	_____	_____
Ever feel as though your heart is skipping beats or have runs of irregular rhythm?	_____	_____
Have you ever been told you have a heart murmur?	_____	_____
Any family members die suddenly before the age of 50?	_____	_____
Any congenital defect such as a single kidney, undescended testicle or cardiac defect?	_____	_____
Do you have any hernias, groin or abdominal?	_____	_____
Have you ever had a head injury or concussion? If YES , when? ____/____/____	_____	_____
Have you ever had a pinched nerve or numbness or tingling in your arms, hands or feet?	_____	_____
Have you ever had a heat stroke? If YES , when? ____/____/____	_____	_____
Do you have any drug allergies? If YES , what: _____	_____	_____

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

MEDICAL QUESTIONS: DOCTOR, PARAMEDIC OR NURSE ONLY BELOW THIS LINE

Physical Check	RESULT	Physical Check	RESULT
Fighters Weight	_____	Fighters Eyes	_____
Fighters Age	_____	Fighters Heart	_____
Fighters Pulse	_____	Fighters Lungs	_____
Fighters Blood Pressure	_____	Fighters Hernia/Abd.	_____
Fighters Hands	_____	Physical Look	_____

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