

IKF FIGHTER PHYSICAL EXAMINATION

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ONLY A LICENSED PHYSICIAN (MD OR DO) MAY CONDUCT THIS EXAMINATION AND
COMPLETE THIS FORM. PLEASE COMPLETE THIS FORM IN ITS ENTIRETY.



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LAST NAME: _____ FIRSTNAME: _____ MIDDLE INT: _____

ADDRESS
STREET (NO PO BOX) _____ CITY: _____ STATE: _____
ZIP CODE: _____ COUNTRY: _____

TELEPHONE NUMBER

Age: _____ MALE FEMALE BIRTH DATE: (MM / DD / YYYY)
____ / ____ / ____

PHYSICAL HISTORY: Please check all that applies below:

Asthma Blood in urine Allergies Fainting spells Rupture (hernia) Chest pains Operations
 Shortness of breath Swollen joints Rheumatism Diabetes Frequent headaches
 Convulsions (fits) Chronic cough Spitting of blood
 Cerebral hemorrhage or serious head injury - IF YES, PLEASE EXPLAIN:

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

Have you ever undergone any type of surgery? Yes No (State what type and when and be specific):

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

AMATEUR KICKBOXING/MUAY THAI RECORD

WINS: _____ WINS BY KO/TKO: _____
LOSSES: _____ LOSSES BY KO/TKO: _____
LAST TIME SUFFERED TKO/KO LOSS: ____/____/____

AMATEUR MIXED MARTIAL ARTS RECORD

WINS: _____ WINS BY KO/TKO: _____
LOSSES: _____ LOSSES BY KO/TKO: _____
LAST TIME SUFFERED TKO/KO LOSS: ____/____/____

AMATEUR BOXING RECORD

WINS: _____ WINS BY KO/TKO: _____
LOSSES: _____ LOSSES BY KO/TKO: _____
LAST TIME SUFFERED TKO/KO LOSS: ____/____/____

PRO KICKBOXING/MUAY THAI RECORD

WINS: _____ WINS BY KO/TKO: _____
LOSSES: _____ LOSSES BY KO/TKO: _____
LAST TIME SUFFERED TKO/KO LOSS: ____/____/____

PRO MIXED MARTIAL ARTS RECORD

WINS: _____ WINS BY KO/TKO: _____
LOSSES: _____ LOSSES BY KO/TKO: _____
LAST TIME SUFFERED TKO/KO LOSS: ____/____/____

PRO BOXING RECORD

WINS: _____ WINS BY KO/TKO: _____
LOSSES: _____ LOSSES BY KO/TKO: _____
LAST TIME SUFFERED TKO/KO LOSS: ____/____/____

IKF – INTERNATIONAL KICKBOXING FEDERATION

www.IKFKickboxing.com

PRO AND OR AMATEUR KICKBOXER –MUAY THAI FIGHTER PHYSICAL EXAMINATION FORM



FIGHTER'S NAME: _____ **AGE:** _____

PHYSICAL EXAMINATION: General Appearance: _____ / Height: _____ / Weight: _____
Temperature: _____ / Disabling Scars: _____ / Mouth: _____ / Teeth: _____
Tonsils: _____ / Neck: _____ / Pulse At Rest: _____ / Pulse After 100 Hops: _____
Blood Pressure: At Rest: _____ / After 100 Hops: _____ / 2 Minutes Later: _____
Enlarged Glands: ___ Yes ___ No / Goiter: ___ Yes ___ No / Heart: Pulse Rhythm ___ Regular ___ Irregular
Murmurs: ___ Yes ___ No – Musculoskeletal System: _____
Apical Impulse: ___ Heavy ___ Normal / Enlargement: ___ Yes ___ No / Lungs: Rales ___ Yes ___ No
Abdomen: Enlargement of Liver ___ Yes ___ No / Breasts: Mass ___ Yes ___ No / Tenderness ___ Yes ___ No
Discharge ___ Yes ___ No / Enlargement of Spleen: ___ Yes ___ No – Hernia: ___ Yes ___ No
Testicles: Normal ___ Yes ___ No

REMARKS: _____

Reflexes: Pupils _____ / Knee jerks _____ / Romberg _____ / Babinski _____
Skin: Tone _____ / Rash _____ / Boils _____ / Other: _____
Unhealed wounds: _____
Remarks: _____

EYE HISTORY: Have you ever had any of the following conditions:

Blurred vision? ___ Yes ___ No / If YES, please explain in full: _____

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 / If YES, please explain in full: _____

Have you ever been diagnosed by a physician to have significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, or dislocated lens? ___ Yes ___ No – If YES, please explain in full: _____

EYE EXAMINATION: Vision Without Glasses: Right _____ Left _____

Vision With Glasses Right _____ Left _____ / Visual Fields: Right _____ Left _____

EXAMINING PHYSICIAN: Based on your personal observation and review of the test results it is 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:

LICENSED PHYSICIAN'S NAME (Print)

MEDICAL LICENSE NO.

APPLICANT NAME (Print)

ADDRESS / CITY / STATE / ZIP CODE

APPLICANT SIGNATURE

TELEPHONE NUMBER

DATE/TIME

PERSON WHO ASSISTED'S NAME (Print)

PHYSICIAN'S SIGNATURE

PERSON WHO ASSISTED'S SIGNATURE

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