

2012 IKF WORLD CLASSIC TOURNAMENT – JULY 20TH, 21ST & 22ND, Orlando, FL, USA
AMATEUR KICKBOXER / MUAY THAI FIGHTER PHYSICAL EXAMINATION
 (916) 663-2467 - FAX: (916) 663-4510 – main@IKFKickboxing.com - www.IKFKickboxing.com

YOU MUST BRING THIS COMPLETED FORM WITH YOU TO REGISTER – PLEASE PRESENT TO PHYSICIAN CONDUCTING YOUR PRE-FIGHT PHYSICAL AT REGISTRATIONS ON FRIDAY, JULY 20TH.

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

PAGE 1 OF 2

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: <input type="checkbox"/> Asthma <input type="checkbox"/> Blood in urine <input type="checkbox"/> Allergies <input type="checkbox"/> Fainting spells <input type="checkbox"/> Rupture (hernia) <input type="checkbox"/> Chest pains <input type="checkbox"/> Operations <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Swollen joints <input type="checkbox"/> Rheumatism <input type="checkbox"/> Diabetes <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Convulsions (fits) <input type="checkbox"/> Chronic cough <input type="checkbox"/> Spitting of blood <input type="checkbox"/> Cerebral hemorrhage or serious head injury - IF YES, PLEASE EXPLAIN: _____ _____		
When was the last time you took any type of medication or drug? <i>(State what type and when and be specific):</i> _____		
Have you ever undergone any type of surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(State what type and when and be specific):</i> _____		
When was the last time you took any type of vitamin supplement? <i>(State what type and when and be specific):</i> _____		
AMATEUR KICKBOXING 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 MUAY THAI 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: ____/____/____	



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 is it your medical opinion that this applicant is physically fit to compete as a Full Contact Kickboxer or Muay Thai Fighter as much as two bouts per day in the 2012 IKF World Classic Tournament on July, 21st & 22nd, in Orlando, Florida. ___ 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**

IKF – INTERNATIONAL KICKBOXING FEDERATION

www.IKFKickboxing.com

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