# IKF FIGHTER FULL PHYSICAL EXAMINATION

(916) 663-2467 – ikftoni@outlook.com

**ONLY A LICENSED PHYSICIAN ( MD OR DO ) MAY CONDUCT THIS EXAMINATION AND FULLY COMPLETE THIS FORM NO MORE THAN 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*

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## 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: ___/___

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## 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: _____/_____/_____**