

IAB FIGHTER PRE-BOUT PHYSICAL FORM



Event Date: ____/____/____
 Promoter: _____
 Event City: _____
 Event State: _____
 Event Country: _____

FIGHTERS FULL NAME _____

AGE: ____ - DOB: ____/____/____

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

PLEASE CHECK YES or NO At Right To The Following Questions	YES	NO
Do you have medical insurance?	<input type="checkbox"/>	<input type="checkbox"/>
Any chronic medical conditions? (Diabetes, asthma, heart condition etc.)	<input type="checkbox"/>	<input type="checkbox"/>
If chronic medical conditions Please Explain:		
Ever had any surgery	<input type="checkbox"/>	<input type="checkbox"/>
If Had Surgery Please Explain:		
Ever been Hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
If Hospitalized Please Explain:		
Ever had a fracture or dislocation? If yes, when? ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
Ever had a sprain or strain requiring special equipment or braces? If yes, when? ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
Any vision problems?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out while exercising? If yes, when? ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pains while exercising? If yes, when? ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever felt dizzy while exercising? If yes, when? ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had wheezing or coughing while exercising? If yes, when? ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told you have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Ever feel as though your heart is skipping beats or have runs of irregular rhythm?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
Any family members die suddenly before the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a congenital defect such as a single kidney, undescended testicle or cardiac defect?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any hernias, groin or abdominal?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a head injury or concussion? If yes, when? ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked unconscious? If yes, when? ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a pinched nerve or numbness or tingling in your arms, hands or feet?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a heat stroke? If yes, when? ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any drug allergies? If yes, what:	<input type="checkbox"/>	<input type="checkbox"/>

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

MEDICAL QUESTIONS: Doctor 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	_____

DR. Signature: _____ Print Name: _____ Date: ____/____/____