ISCF 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.

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 MIXED MARTIAL ARTS RECORD
WINS: _______ WINS BY KO/TKO: ______
LOSSES: ______ LOSSES BY KO/TKO: _______
LAST TIME SUFFERED TKO/KO LOSS: ____/____/____

AMATEUR KICKBOXING/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: ____/____/____

PRO MIXED MARTIAL ARTS 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 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 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**

ISCF – INTERNATIONAL SPORT COMBAT FEDERATION
PRO AND OR AMATEUR MIXED MARTIAL ARTS FIGHTER PHYSICAL EXAMINATION FORM