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) ___Heart Murmur ___Chronic Cough ___Spitting of Blood ___Cerebral Hemorrhage Or Serious Head Injury - IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN:

_____

_____

When was the last time you took any type of medication or drug? (*State what type and when and be specific*):
DATE: ___/ ___ / ___ - _____

_____

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*):
DATE: ___/ ___ / ___ - _____
When was the last time you were knocked out? (*State if in Training, Fight Competition, NON Competition*):
DATE: ___/ ___ / ___

_____

Have you ever suffered a loss of consciousness? (*State if in Training, Fight Competition, NON Competition*):
DATE: ___/ ___ / ___

_____

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 Mixed Martial Arts Fighter.. ___**Yes** ___**No -** If no, please explain:
_____
_____

PHYSICIAN'S STAMP REQUESTED PLEASE

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

Fighters over the age of 40 must submit additional medical work a minimum 15 days prior to scheduled bout.
See ISCF website for links to additional medical work or contact the ISCF directly at info@iscfmma.com