# 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? | | |
| Any chronic medical conditions? (Diabetes, asthma, heart condition etc.) | | |
| If chronic medical conditions<br>Please Explain: | | |
| Ever had any surgery | | |
| If Had Surgery<br>Please Explain: | | |
| Ever been Hospitalized? | | |
| If Hospitalized<br>Please Explain: | | |
| Ever had a fracture or dislocation? If yes, when? ____/____/____ | | |
| Ever had a sprain or strain requiring special equipment or braces? If yes, when? ___/___/___ | | |
| Any vision problems? | | |
| Do you wear contact lenses? | | |
| Have you ever passed out while exercising? If yes, when? ____/____/____ | | |
| Have you ever had chest pains while exercising? If yes, when? ____/____/____ | | |
| Have you ever felt dizzy while exercising? If yes, when? ____/____/____ | | |
| Have you ever had wheezing or coughing while exercising? If yes, when? ____/____/____ | | |
| Have you ever been told you have high blood pressure? | | |
| Ever feel as though your heart is skipping beats or have runs of irregular rhythm? | | |
| Have you ever been told you have a heart murmur? | | |
| Any family members die suddenly before the age of 50? | | |
| Do you have a congenital defect such as single kidney, undescended testicle, cardiac defect? | | |
| Do you have any hernias, groin or abdominal? | | |
| Have you ever had a head injury or concussion? If yes, when? ____/____/____ | | |
| Have you ever been knocked unconscious? If yes, when? ____/____/____ | | |
| Have you ever had a pinched nerve or numbness or tingling in your arms, hands or feet? | | |
| Have you ever had a heat stroke? If yes, when? ____/____/____ | | |
| Do you have any drug allergies? If yes, what: | | |

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

**MEDICAL QUESTIONS: Doctor (MD) 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 | _____ |

**D/P/N Signature:** _____ **Print Name:** _____ **Date:** ____/____/____