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 Please Explain:		
Ever had any surgery		
If Had Surgery Please Explain:		
Ever been Hospitalized?		
If Hospitalized 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, Paramedic or Nurse 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:** ____/____/____