World Kickboxing Association

Comprehensive Amateur Physical Examination Report

Front To be Completed by Fighter

Name of Event: **2021 WKA USA Nationals** Date of Event: **August 27-29, 2021**
First Name: _____ Last Name: _____ DOB: _____ ○ Male ○ Female
Street Address: _____ City: _____ State: _____ Zip: _____
Country: _____ Phone: ( ) _____
Email: _____ **** Will receive WKA Fighter License via email**
Do you have a Health Insurance? ○ yes ○ no If so, with what company? _____

Medical History:
Have you ever had, or do you currently have any of the following conditions? Please check boxes of all that apply.

1. Blood Disorder or Anemia		19. Hepatitis	
2. Seizure or Convulsions		20. Diabetes	
3. Rheumatic Fever		21. Physical Impairment	
4. Asthma or Shortness of Breath		22. Skin Disease or Rash	
5. High Blood Pressure		23. Chronic Cough	
6. Heart Disease or Heart Murmur		24. Headaches	
7. Chest pain, discomfort, or pressure		25. Swollen Joint, Joint Injury, or Dislocation	
8. Tuberculosis		26. Sprain, Muscle or Ligament Tear, Tendonitis	
9. Marfan Syndrome		27. Severe muscle cramps	
10. Rheumatism or Arthritis		28. Neck or Spine disorder or instability	
11. Sickle Cell Disease or trait (in self or family member)		29. Spitting or Coughing of Blood	
12. Kidney, Lung, Testicle or Eye removed		30. Surgery or Hospitalization	
13. Kidney Disease, Single or Horseshoe kidney		31. Substance Abuse	
14. Concussion or Unconsciousness		32. Communicable Disease	
15. Mononucleosis		33. Fracture or Stress Fracture	
16. Allergies		34. Rupture or Hernia	
17. Blurring of Vision or other eye/vision problems		35. Dizziness or Fainting Spells	
18. Wear/ have worn Glasses or Contact lenses		36. Numbness, weakness, or tingling in arms or legs	

Name of Primary Care Physician / Family Doctor: _____

If you checked any of the above boxes, please explain fully: _____

Do you have any other information concerning your health, past or present, which is not covered by the above questions? (if yes, describe fully): _____

Are you taking any Medications or Drugs? _____ Please list and give the name of the prescribing doctor:

Date of Last Fight: ____/____/____
How Many Knock Outs have you suffered? KO _____ TKO _____ Date of Last KO ____/____/____
Longest duration of unconsciousness _____ (# of min, hour, days)
Length of time before returning to contact _____
Have you ever been knocked unconscious in any other sport or activity? _____
What is your average non-fight weight? _____

Signature of Fighter: _____

To be Completed by Physician

Physical Examination for: _____

Height: _____ Weight: _____ Blood Pressure: _____ Temperature: _____ Pulse: _____

General appearance: _____

HEENT: _____

Pupils: Reg _____ Round _____ Equal _____ React Light _____ Accom _____
OD OS Periorbital scars
Acuity _____ _____ _____

Oropharynx: _____

Neck: LA _____ Goiter _____ ROM _____

Lungs: _____

Heart: _____

Abd: _____

Inguinal region: _____

Cervical Spine/Neck: _____

Back: _____

Shoulders: _____

Arm/Elbow/Wrist: _____

Knees: _____

Ankles: _____

Hips: _____

Hands/Feet/Small Joints: _____

Skin: _____

Neuro: _____

Gait: _____ Rhomberg: _____ FNF: _____ RAM: _____

Muscle stretch reflexes: _____ Motor: _____ Sensory: _____

Orientation: Self, time, place: _____

Mental assessment: _____

Contestant is physically and mentally fit to fight in a Combative Martial Arts competition. O Yes O No

Physician's Signature: _____ Date of Exam: _____/_____/_____
Physician's Name: _____ Practice/Company (if applicable): _____
Physician License Number: _____ State of License: _____
Street Address: _____ City _____ State: _____ Zip: _____
Phone :( ) _____