



Combat Sports League

WKA USA Sanctioned

Comprehensive Fighter Physical

First Name: _____ Last Name: _____
 Street Address: _____ City _____
 State: _____ Zip: _____ Country: _____
 Phone :() _____ Email: _____
 Date of Birth: _____ Male Female
 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? _____

Physical Examination:

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

General appearance: _____

HEENT: _____

Pupils: Reg _____ Round _____ Equal _____ React Light _____ Accom _____

Acuity OD _____ OS _____ Periorbital scars _____

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: _____ Romberg: _____ FNF: _____ RAM: _____

Muscle stretch reflexes: _____ Motor: _____ Sensory: _____

Orientation: Self, time, place: _____

Mental assessment: _____

I have examined the above contestant on (date): _____

I have determined the above contestant to be physically and mentally fit to fight in a Mixed Martial Arts competition:
 yes no

Physician's Signature: _____

Physician's Name: _____ Practice/Company (if applicable): _____

Physician License Number: _____ State of License: _____

Street Address: _____ City _____

State: _____ Zip: _____ Phone :() _____