



# World Kickboxing Association



## Comprehensive Pre-bout Physical Examination Report

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 Combative 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 :( ) \_\_\_\_\_