

To be completed prior to your first event and carried with you at ALL TIMES



ANNUAL PHYSICAL EXAMINATION DATE: _____

CONTESTANT'S NAME: _____

SS #: _____ **DATE OF BIRTH:** _____

FEDERAL/NATIONAL ID# _____ **CURRENT WEIGHT:** ____ **HEIGHT** _____

EXAMINATION TO BE COMPLETED BY LICENSED PHYSICIAN (MD) ONLY:

- UNLESS STATED Indicate normal findings by placing a check on each line
- VISION must be at least **20/70** without corrective lenses

1. Visual Acuity: **List Actual** _____ Peripheral Vision (**DEGREES**) _____

2. Pupils: Regular _____ Equal _ React to light _____ Anterior Segment _____

3. Periorbital Regions (describe scars, if any) _____

4. Oropharynx: _____ Ears (discharge, etc.) _____

5. Lungs: (Any abnormal breath sounds, friction rub, rales, etc.) _____

6. Heart Rate: **List Actual** _____ Irregularity _____ Murmur _____

7. Pulse Rate: **List Actual** _____ Blood Pressure: **List Actual** _____

8. Abdominal Exam: _____

9. Extremities (Stiffness, swelling, tenderness): **YES** _ **NO** _____

10. Hands (fists): Any Fractures or Swelling: **YES** _____ **NO** _____

11. Nervous System: Orientation _____ Cerebellum _____ Cranial Nerves __

12. Nose: Instability **YES** _____ **NO** _____ Obstruction **YES** _____ **NO** _____

13. Coordination: Finger to Nose - Normal _____ Abnormal _____

14. Tandem Gait: Normal _____ Abnormal _____

15. History of any irregular symptoms

Yes	No
Yes	No

Chest Pains

Shortness of Breath

Loss of consciousness

Duration of unconscionness

Fainting with /without exercise

unexplained Weakens

Unexplained Weight loss

Neck or back Pain

Headaches

Unexplained Weakness

16.	Physical Exam Results Normal		Yes	No
	Head	Heart		
	Eyes	Abdomen		
	Extremities	Vision		
	Neck	Lungs		
	Neurological Exam	Skin		

17. DOES THE PATIENT SPECIFICALLY SHOW ANY evidence of any of the following?				
	Yes	No	Yes	No
Retinal injury/ detachment			Cardiac Disease	
Neurological deficit			Respiratory Disorder	
Post concussive syndrome			any loss of paired organs	
Intracranial Aneurysm			Cervical Disorder	
Prescription medications			drug allergies/supplements	

Additional information or comments.

You must provide verification of blood testing as required for proof of:
 Negative Hepatitis B and C (within six months)
 Negative HIV (within six months)
 EKG Results (within 1 year)
 Would there be any other medical issue that would impair the athlete's ability to participate in competitive combative sports such as categorized as Kickboxing or Mixed Martial Arts?

15. Patient/ Athlete's responsibility to obtain and carry your annual medical assessment and proof of blood work to all events and to provide this information to the pre fight physical physician for review. It is your responsibility to retain this as your private and personal information.

16. Based upon the above information, physical exam and test results, this individual appears to be in good physical condition to compete in competitive combative sports categorized as Kickboxing or Mixed Martial Arts YES _____ NO _____
 IF NO, STATE REASON(S) _____

PHYSICIAN'S SIGNATURE: _____ **DATE:** _

NAME OF PHYSICIAN (PRINT): _____

Medical License # and State of issuance # _____

TELEPHONE #: _____ **FAX #:** _____

KIMed5.26.10

