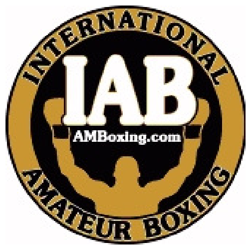


IAB – INTERNATIONAL AMATEUR BOXING

FULL FIGHTER PHYSICAL FORM

ONLY A LICENSED PHYSICIAN (MD OR DO) MAY CONDUCT THIS EXAMINATION AND COMPLETE THIS FORM.
PLEASE COMPLETE THIS FORM IN ITS ENTIRETY.

LAST NAME: ______________________________ **FIRSTNAME:** ______________________________ **MIDDLE INT:** _____

ADDRESS
STREET (NO PO BOX) __________________________________ **CITY:** ___________________________ **STATE:** ______
ZIP CODE: __________________ **COUNTRY:** ____

TELEPHONE NUMBER

Age:	_____**MALE** _____**FEMALE**	**BIRTH DATE: (MM / DD / YYYY)** _____/_____/_____

PHYSICAL HISTORY: Please check all that applies below:

____**Asthma** ____**Blood in urine Allergies** ____**Fainting spells** ____**Rupture (hernia)** ____**Chest pains** ____**Operations**
____**Shortness of breath** ____**Swollen joints** ____**Rheumatism** ____**Diabetes** ____**Frequent headaches**
____**Convulsions (fits)** ____**Chronic cough** ____**Spitting of blood**
____**Cerebral hemorrhage or serious head injury - IF YES, PLEASE EXPLAIN:**
____
____

When was the last time you took any type of medication or drug? (*State what type and when and be specific*):
____
____

Have you ever undergone any type of surgery? ____ Yes ____ No (*State what type and when and be specific*):
____
____

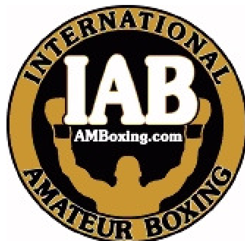
When was the last time you took any type of vitamin supplement? (*State what type and when and be specific*):
____

AMATEUR BOXING RECORD – IF ANY
WINS: _______ WINS BY KO/TKO: ______
LOSSES: ______ LOSSES BY KO/TKO: _______
LAST TIME SUFFERED TKO/KO LOSS: ____/____/____

AMATEUR KICKBOXING RECORD – IF ANY
WINS: _______ WINS BY KO/TKO: ______
LOSSES: ______ LOSSES BY KO/TKO: _______
LAST TIME SUFFERED TKO/KO LOSS: ____/____/____

AMATEUR MIXED MARTIAL ARTS RECORD – IF ANY
WINS: _______ WINS BY KO/TKO: ______
LOSSES: ______ LOSSES BY KO/TKO: _______
LAST TIME SUFFERED TKO/KO LOSS: ____/____/____

AMATEUR MUAY THAI RECORD – IF ANY
WINS: _______ WINS BY KO/TKO: ______
LOSSES: ______ LOSSES BY KO/TKO: _______
LAST TIME SUFFERED TKO/KO LOSS: ____/____/____



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FIGHTER'S NAME: ____ **AGE:** ________

PHYSICAL EXAMINATION: General Appearance: ____________________ / Height: ______ / Weight: _______
Temperature: ________ / Disabling Scars: ____________ / Mouth: ___________ / Teeth: _____________
Tonsils: ________ / Neck: ________ / Pulse At Rest: _________ / Pulse After 100 Hops: ____________
Blood Pressure: At Rest: ___________ / After 100 Hops: ___________ / 2 Minutes Later: ___________
Enlarged Glands: ____Yes ____ No / Goiter: ____Yes ____No / Heart: Pulse Rhythm ____Regular ____Irregular
Murmurs: ____Yes ____No – Musculoskeletal System: ____
Apical Impulse: ___Heavy ___Normal / Enlargement: ____Yes ____No / Lungs: Rales ____Yes ____No
Abdomen: Enlargement of Liver ___Yes ___No / Breasts: Mass ____Yes ____No / Tenderness ____Yes ____No
Discharge ____Yes ____No / Enlargement of Spleen: ____Yes ____No – Hernia: ____Yes ____No
Testicles: Normal ____Yes ____ No

REMARKS: ____
____

Reflexes: Pupils __________ / Knee jerks ____________ / Romberg ___________ / Babinski ___________
Skin: Tone ____________ / Rash ____________ / Boils ____________ / Other:__________________
Unhealed wounds: ____
Remarks: ____
____

EYE HISTORY: Have you ever had any of the following conditions:
Blurred vision? ___Yes ___No / If YES, please explain in full:_______________________________________
____

Have you ever had any surgical procedures done to your eye(s) or the tissues around your eye(s) other than simple sutures of the skin around the eye? ____Yes ____No / If YES, please explain in full: ______________________________
____

Have you ever been diagnosed by a physician to have significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, or dislocated lens? ___Yes ___No – If YES, please explain in full:
____

EYE EXAMINATION: Vision Without Glasses: Right ____________ Left ____________

Vision With Glasses Right ____________ Left ____________ / Visual Fields: Right ____________ Left ____________

EXAMINING PHYSICIAN: Based on your personal observation and review of the test results is it your medical opinion that this applicant is physically fit to compete as Full Contact BOXER. ___**Yes** ___**No** If no, please explain:
____
____

______________________________	______________________	______________________________
LICENSED PHYSICIAN'S NAME (Print)	**MEDICAL LICENSE NO.**	**APPLICANT NAME (Print)**

______________________________________ ______________________________________
ADDRESS / CITY / STATE / ZIP CODE **APPLICANT SIGNATURE**

______________________	______________________	______________________________
TELEPHONE NUMBER	**DATE/TIME**	**PERSON WHO ASSISTED'S NAME (Print)**

______________________________________ ______________________________________
PHYSICIAN'S SIGNATURE **PERSON WHO ASSISTED'S SIGNATURE**

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