USFL FIGHTER PRE-BOUT PHYSICAL FORM

_____

FIGHTERS FULL NAME

AGE: _____ - DOB: _____/_____/_____

FIGHTER: Please answer ALL of the following Questions Before your fighter physical check below		
PLEASE CHECK YES or NO At Right To The Following Questions	**YES**	**NO**
Do you have medical insurance?	_____	_____
Any chronic medical conditions? (Diabetes, asthma, heart condition etc.)	_____	_____
Please Explain:		
Ever had any surgery	_____	_____
Please Explain:		
Ever been Hospitalized?	_____	_____
If Hospitalized Please Explain:		
Ever had a fracture or dislocation? If yes, when? ____/____/____	_____	_____
Ever had a sprain or strain requiring special equipment or braces? If yes, when? ___/___/___	_____	_____
Any vision problems?	_____	_____
Do you wear contact lenses?	_____	_____
Have you ever passed out while exercising? If yes, when? ____/____/____	_____	_____
Have you ever had chest pains while exercising? If yes, when? ____/____/____	_____	_____
Have you ever felt dizzy while exercising? If yes, when? ____/____/____	_____	_____
Have you ever had wheezing or coughing while exercising? If yes, when? ____/____/____	_____	_____
Have you ever been told you have high blood pressure?	_____	_____
Ever feel as though your heart is skipping beats or have runs of irregular rhythm?	_____	_____
Have you ever been told you have a heart murmur?	_____	_____
Any family members die suddenly before the age of 50?	_____	_____
Do you have a congenital defect such as single kidney, undescended testicle, cardiac defect?	_____	_____
Do you have any hernias, groin or abdominal?	_____	_____
Have you ever had a head injury or concussion? If yes, when? ____/____/____	_____	_____
Have you ever been knocked unconscious in training OR in a fight? If yes, when? ____/____/____	_____	_____
Have you ever had a pinched nerve or numbness or tingling in your arms, hands or feet?	_____	_____
Have you ever had a heat stroke? If yes, when? ____/____/____	_____	_____
Do you have any drug allergies? If yes, what:	_____	_____
What medications are you currently taking:_____	_____	_____

Fighters Signature: _____ Print Name:_____ Date: _____

MEDICAL QUESTIONS: Doctor, Paramedic or Nurse Only Below This Line

Physical Check	**RESULT**		**Physical Check**	**RESULT**
Fighters Weight	_____		Fighters Eyes	_____
Fighters Age	_____		Fighters Heart	_____
Fighters Pulse	_____		Fighters Lungs	_____
Fighters Blood Pressure	_____		Fighters Hernia/Abd.	_____
Fighters Hands	_____		Physical Look	_____

D/P/N Signature: _____ Print Name:_____ Date: _____