USFL FIGHTER PRE-BOUT PHYSICAL FORM

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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:____________________________________	________	________

Parents 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: __________