

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: _____		

Parent/ Guardian 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:** _____