FIGHTERS: Please provide the requested information on the TOP HALF of this form.

Thank You

PHYSICIAN'S REPORT PRE-EVENT PHYSICAL EXAMINATION

FIGHTER FILLS THIS OUT

DATE___/___/____ TIME___:____ CITY_____ PROMOTER_____

FIGHTER'S NAME:_____ LICENSE #:_____
(LAST) (FIRST)

ADDRESS:_____ CITY:_____ STATE:___ ZIP CODE:_____

PHONE:HOME(____)_____ WORK(____)_____ DOB____/____/_____ SEX____

RECORD: WINS____ LOSSES____ DRAWS____ KO'S____ SS#_____

DATE OF LAST FIGHT___/___/____ OPPONENT_____ OUTCOME_____

PROMOTER_____ CITY_____ COUNTRY_____

AGE_____ HEIGHT_____ WEIGHT_____ ALLERGIES_____

MEDICATIONS_____

PRESENT ILLNESS/INJURY_____

DOCTOR FILLS THIS OUT

EYES: LEFT_____ RIGHT_____ EARS: LEFT_____ RIGHT_____

HEAD_____ NOSE_____ THROAT_____ NEUROLOGICAL_____

CHEST_____ CARDIOVASCULAR_____ ABDOMEN_____

MUSCULAR SKELETAL_____ GENITO-URINARY_____

PULSE_____ BLOOD PRESSURE____/___ REMARKS_____

HEP B _____ HEP C _____ HIV _____ PREGNANCEY _____

PERSONAL PHYSICIANS LETTER _____

CLEARED FOR CONTEST?: YES____ NO____ PHYSICIAN'S NAME_____

PHYSICIAN'S SIGNATURE_____ TYPE OF PRACTICE_____