



## Pre-Bout Physical Examination Questionnaire – Page 1 of 2

### Part 1 – To be completed by the Athlete, or parent/legal guardian if under legal age

Name (Last, First, Middle) \_\_\_\_\_ / / \_\_\_\_\_  
Date of Birth

Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Name of Physician \_\_\_\_\_ City/Province \_\_\_\_\_ Emergency Contact Person/Number \_\_\_\_\_

**Medical History:** Have you ever had, or do you currently have any of the following? (Check all that Apply)

**Please Expand/Explain:**

Bleeding Disorder	Chronic Cough	
Seizure or Convulsions	Headaches	
Persistent Undiagnosed Pain	Swollen Joints	
Asthma or Shortness of Breath	Joint Injury or Dislocation	
High Blood Pressure	Fractures	
Heart Disease	Dizziness or Fainting	
Blood Disorders (Sickle Cell)	Rupture of organ or Hernia	
Loss of one of a paired organ	Osteo or Rheumatoid Arthritis	
Kidney Disease/Horseshoe Kidney	Communicable Disease (HIV, Mononucleosis, Hepatitis etc.)	
Mononucleosis/Hepatitis	Substance Abuse	
Blurred Vision		
Allergies		
Glasses/Contacts		
Diabetes		
Skin Disease or Rash		

**NONE of the Above Apply: Y\_ N\_\_**

Do you have any other information concerning your health, past or present which is not covered by the above questions? (If yes, describe fully) \_\_\_\_\_

Female Athletes: Are You Pregnant Y N Last Menstruation: \_\_\_\_\_

Are you taking any medications? (Please List) \_\_\_\_\_

## PRE-BOU T PHYSICAL EXAMINATION – Page 2 of 4

### Weight Loss

Athlete's Average Non-Fight Weight: \_\_\_\_\_ Weight Loss/Gain within the last week (Kg/Lbs): \_\_\_\_\_

### Athlete's Fight History

Date of Last Fight: \_\_\_\_\_

Have you received a concussion in Combative Sports or any other Sport or Activity? Y N

When: \_\_\_\_\_

How Many Concussions have you had? \_\_\_\_\_

How many of the Following have you sustained? KO \_\_\_\_ RSC (INJURY) \_\_\_\_

When: \_\_\_\_\_

When were you cleared by a physician to participate (following your last concussion): \_\_\_\_\_

Name of Physician: \_\_\_\_\_

Have your ever been suspended because of an injury in WAKO or any other organization? Yes \_\_\_\_ No \_\_\_\_

### Applicant

I declare that all the above-mentioned information is true and that I have not intentionally misrepresented any facts about my past or current medical history. I understand that the history, and Pre-Event Physical is provided as screening tool for my safety. It does not replace annual and regular examinations by a primary care physician or family physician. I certify "I have been cleared for Combative sport activity by my regular physician." I authorize WAKO and/or its representatives (which include, but are not limited to Ringside staff and physicians and/or Provincial Affiliate) to photocopy this record and maintain it on file.

I release all of my medical records, by all of my treating physicians and hospitals, which may include; medical history, findings, diagnoses, diagnostic test results and prognoses.

I further release, promise to hold harmless, and covenant not to sue the ringside physicians, and/or agents, institutions or firms providing the information which I have released. I sign this waiver voluntarily and of my own free will.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Participant Date Parent or Legal Guardian (If under 18) \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date



**PRE-BOUT PHYSICAL EXAMINATION – Page 3 of 4**  
**To be completed by the Medical Staff/Physician**

**Athlete's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

- The Physical Examination is to be signed by a physician and/or Medical Staff.
- A check or no entry indicates normal findings.

**Areas of Concern from Questionnaire:** \_\_\_\_\_  
\_\_\_\_\_

**General:**

Blood Pressure: \_\_\_\_\_ Pulse Rate: \_\_\_\_\_ Respiratory Rate: \_\_\_\_\_  
Temperature: \_\_\_\_\_ Observable Skin Rashes/Conditions: \_\_\_\_\_  
Athlete's General Appearance: \_\_\_\_\_

**Concerns:**

**Orthopaedics: (Neck/Back/Extremities):**

Range of Motion: (Pain or Limitation) Neck \_\_\_\_\_ Back \_\_\_\_\_ Extremities \_\_\_\_\_

Findings:

**Concerns:**

**Neurological Examination:**

Orientation to Person, Place and Time: (GCS /15) \_\_\_\_\_ Romberg: \_\_\_\_\_ Pronator Drift: \_\_\_\_\_  
Other: \_\_\_\_\_

Reflexes (Upper/Lower Extremity - Optional) \_\_\_\_\_ Sensory: \_\_\_\_\_ Motor: \_\_\_\_\_

Pupils: Observations (Periorbital Scars/Other): \_\_\_\_\_

P.E.A.R.L.A (Pupils Equal and Reactive to Light & Accommodation) \_\_\_\_\_

Tracking \_\_\_\_\_ Nystagmus \_\_\_\_\_ Other: \_\_\_\_\_

**Concerns:**

## PRE-BOU PHYSICAL EXAMINATION – Page 4 of 4

### Areas of Concern from Page 1:

\_\_\_\_\_  
\_\_\_\_\_

### **Eyes, Ears, Nose, Throat:**      Applicable/Non-Applicable

Eyes: (Other than Cranial Nerves) \_\_\_\_\_

Nose: \_\_\_\_\_

Throat: \_\_\_\_\_ Lymph Nodes: \_\_\_\_\_ Goiter: \_\_\_\_\_

**Concerns:** \_\_\_\_\_

### **Cardiopulmonary:**      Applicable/Non-Applicable

Heart: \_\_\_\_\_

Lungs: \_\_\_\_\_

Comments: \_\_\_\_\_

**Concerns:** \_\_\_\_\_

### **Abdominal/Pelvic:**      Applicable/Non-Applicable

Abnormalities on Palpation:    Y    N      Where: \_\_\_\_\_

Organomegaly:                    Y    N      Where: \_\_\_\_\_

Inguinal: \_\_\_\_\_

Comments: \_\_\_\_\_

**Concerns:** \_\_\_\_\_

**Other:** \_\_\_\_\_

**Follow Up:** \_\_\_\_\_

**I hereby declare this athlete to be: ( ) Fit,    ( ) Unfit to participate in this WAKO event.**

**Practitioner's Name:** \_\_\_\_\_ **Credentials:** \_\_\_\_\_

**Practitioner's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Event Location:** \_\_\_\_\_