KENTUCKY BOXING AND WRESTLING COMMISSION

656 Chamberlin Avenue, Suite B,
Frankfort, Kentucky 40601

Email: KBWC@ky.gov
Phone: (502) 564-0085
Fax: (502) 696-3938

Pre-Fight Medical Questionnaire

Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

Emergency Contact: _____ Telephone: _____

Competition Record: W_____ L _____ Number of times you have been KO'd: _____

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Medical History

Medication allergies: _____

List any medicine or drugs used: _____

List any substance abuse (drugs, tobacco, alcohol): _____

Prior surgery: _____

Overnight hospitalizations: _____

Recommended evaluations (scans, x-ray, EKG, EEG, stress test): _____

Do you currently have any "training injuries": _____

Have you missed any training in the past 3 weeks: _____

Have you ever been diagnosed with a concussion? If so, how many? _____

Do you have a history of migraines? _____

Do you suffer from any type of headache other than a migraine? If so, what type? _____

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HEAD, EARS, EYES, NOSE, AND THROAT	NO	YES
Have you ever experienced or been diagnosed with the following:		
KO/"bell rung"/ unconscious, suffered a concussion (including childhood injuries)		
Seizure / convulsions?		
Recent headaches/dizziness/impaired memory?		
Double vision / blurred vision?		
Retinal detachment?		

HEAD, EARS, EYES, NOSE, AND THROAT (continued)	NO	YES
Glasses or contact lenses?		
Vision much worse in one eye than the other?		
Hearing difficulty or ruptured eardrum?		
Broken nose?		
Recent sore throat?		
Cold sores/fever blisters/herpes simplex?		
HEART & LUNGS		
Fainted while exercising?		
Chest pain/heart murmur/irregular heart beat?		
High blood pressure/rheumatic or scarlet fever?		
Asthma/bronchitis/T.B./wheezing?		
Heart stroke or heat exhaustion?		
EXTREMITIES		
Broken/fractured a bone or had a cast? If yes please list date and bone.		
Severe sprain/torn ligament or injured joint?		
Swollen joints?		
Spinal injury or ruptured disks?		
Loose of broken teeth?		
Facial fractures, including the jaw?		
SYSTEMIC		
Diabetes?		
Bleeding disorder or poor clotting?		
Hepatitis?		
HIV or AIDS?		
Has a close relative died before the age of 50 of heart disease or unknown cause?		
Recent fever or chills?		
ABDOMEN		
Hernia or rupture?		
Single kidney or single testicle?		
Blood in urine?		
Vomiting or diarrhea in the past 3 weeks?		
FEMALES		
Are you pregnant?		
Regular menstruation?		
Have you missed a period?		

Please list your primary care physician's information below:
Physician Name: _____ Telephone: _____

Address: _____

****

I certify under penalty of perjury that, to the best of my knowledge, my answers to the above questions are correct.

Competitor's Signature: _____ Date: _____

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PRE-FIGHT Examination

Contestant Name: _____ Height: _____ Weight: _____

Vision (optional) Right: _____ Left: _____ Pulse: _____ B.P.: _____

HEENT	NORMAL	ABNORMAL
Alert		
PERRL		
Visual fields		
Nasal / Facial tenderness		
Hearing		
Neck supple		
Dental hygiene and TMJ		
Nodes		
Good balance with eyes closed (15 seconds)		
Finger-to-nose test		
HEART & LUNG		
Lungs clear		
Ribs non tender to A-P / Lateral Compression		
No murmurs or Irregular beats		
ABDOMEN		
Non-tender		
No masses		
No hernias or testicular abnormality (by history)		
No organomegaly		
EXTREMITIES		
Full squat and duck walk (heels/ankles)		
Touches toes (spine)		
Full shoulder rotation		
Elbows fully extended		
Wrist and hands (extended/clenched)		
Toes and feet		
SKIN		
Herpes simplex		
Impetigo		
Rashes		
Lacerations		

Cleared:_____ Not Cleared: _____ Reason: _____

Physician Signature: _____ Date: _____

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POST-FIGHT Examination

Physician Examination

Contestant Name: _____

****

Mechanism of injury:

_____

_____

Physical findings:

_____

_____

Impression:

_____

_____

Initial treatment:

_____

_____

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RECOMMENDATIONS

ÿ Fitness Training Only (no contact) ÿ No Practice ÿ No Competition

ÿ Emergency Room Evaluation

ÿ Non- Emergency Physician Follow-Up: _____ Days / _____Weeks

ÿ Restriction: _____ 30 days _____90 days _____180 days _____ days

Physician Signature: _____ Date: _____