



WKF (WORLD KICKBOXING FEDERATION) MEDICAL REPORT

SECTION 1: Combatant to complete and provide to Medical Practitioner (Doctor):

Name of person examined:

Address: _____

A. Date of Birth: / /

B. Present and past occupation/s:

C. Previous involvement in combat sports: _____

Injuries arising from above involvement:

D. Do you consume alcohol? **YES/NO**

E. Do you smoke? **YES/NO**

F. Have you ever been overseas? **YES/NO**

Did you suffer any illness during this time? **YES/NO**

G. Has your weight altered in the past 12 months? **YES/NO**

Increase: _____kg Decrease: _____ kg

H. Within the past five (5) years, have you either occasionally **YES/NO**

or regularly taken any stimulants, sedatives, medication or drugs by mouth or by injection?

If so, provide details and if prescribed by a doctor give full particulars in **Section "I"** below.

I. During the past five (5), years have you had any medical **YES/NO**

examination, advice, treatment, or been in hospital?

If so, give full particulars of each instance (including X-ray, electro-cardiogram or other special tests) below or as an attachment

Date Name & Address of Doctor or Hospital Reason (if illness or injury, give duration &date of recovery)

J. Have you ever had any of the following? Please answer **"Yes"** or **"No"**

If "yes", give date, name and address of doctor (if any) and full particulars including duration.

High blood pressure? **YES/NO**

Pain in chest? **YES/NO**

Rheumatic fever or any heart complaint? **YES/NO**

Indigestion, gastric or duodenal ulcer? **YES/NO**

Asthma, tuberculosis or any other lung disease? **YES/NO**

Bowel, liver or gall bladder disease? **YES/NO**

Epilepsy, fainting attacks or fits of any kind? **YES/NO**

Mental or nervous disorder or breakdown? **YES/NO**

Kidney or bladder disease, including renal colic or stone, pyelitis or cystitis? **YES/NO**

Diabetes, gout, cancer or tumour or any type? **YES/NO**

Coughing of blood, passage of blood from the bowel or in the urine? **YES/NO**

Easy bruising or severe haemorrhage? **YES/NO**

Multiple ligament/bone or joint injuries? **YES/NO**

List below any operations that you have undergone, including the year of the operation:

SECTION 2: Medical Practitioner to complete

K. Is there anything unfavourable in appearance or development? **YES/NO**

Give particulars of any permanent marks or scars: _____

L. Give the following measurements:

Height:cms Weight:kgs

Chest:cms Abdomen at umbilicus:cms

If chest expansion is less than 5 cms please comment as to its apparent cause:

M. What is the pulse rate?per min:BP.....

Is the heart enlarged? **YES/NO**

Is there any abnormality of the heart sounds or rhythm? **YES/NO**

Result of ECG if over 35 years of age? **YES/NO**

Any abnormalities of the vascular system? **YES/NO**

N. Abnormalities:

Is there abnormality of the mouth/head/neck or nose? **YES/NO**

Check ROM of neck. **YES/NO**

State whether dentures are worn. **YES/NO**

Is a hernia present? **YES/NO**

Are there any abnormalities of external genitalia? **YES/NO**

If so, describe abnormalities: _____

Are the liver, spleen or kidneys enlarged or abnormal? **YES/NO**

If so, give particulars: _____

Are there any abnormalities of lymph glands in the neck axillae or inguinal regions? **YES/NO**

If so, give particulars: _____

O. Examination of the urine: Albumin?

Sugar?

The urine should be passed at the time of the examination if not, please state circumstances:

If Albumen is found, an early morning specimen and a further specimen passed later in the day should be examined and findings (including specific gravity) recorded before completing report:

Do you consider the genitor-urinary system to be normal and healthy? **YES/NO**

P. Nervous system:

Sight (acuity) Right: Left:

Are there any abnormalities of the cranial nerves? **YES/NO**

Is there any hearing defect apparent? **YES/NO**

If abnormal, please comment of aetiology and possible investigation:

Eye gaze? _____

Cerebellum function? _____

Body balance/co-ordination? _____

Muscle tone? _____

Muscle strength? _____

Sensation? _____

Any further comments on previous 6 items? _____

Do the trunk and limbs have full ROM? **YES/NO**

Are there any joint abnormalities? **YES/NO**

Is speech normal? **YES/NO**

Is there any evidence of intellectual impairment? **YES/NO**

PROFESSIONAL OPINION:

Q. Do you consider that any medical attendant's reports or any other tests are required?

R. Do you consider the above named person to be predisposed to any particular ailment or injury?

S. Do you consider this person fit to participate in combat sports?

YES/NO With Reservation: _____

T. Additional or other comments (see notes)

U. I certify that the applicant a Male/Female: (delete gender not applicable)

Signature of Medical Practitioner: _____

Please Print Name: _____

Address of Practice: _____

Date: _____ Phone Number: _____ Stamp Here: