The information contained in this medical history form will only be used by the International Federation of Muaythai Amateur for purposes of determining if you pose a health threat/risk to yourself in the ring and to review your past medical history in the event of a new emergency or re-occurrence. This information will remain confidential at all times. Please complete this questionnaire with your physician. Print clearly in BLUE or BLACK ink only.

|  |
| --- |
| **PERSONAL INFORMATION** |
| **LAST NAME:** |  | **FIRST NAME:** |  | **M.I.** |  |
| **D.O.B.** |  | **AGE:** |  | **SEX:** |  | **NATIONALITY:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?** |  |  |  |  |
| **CONDITION:** | **YES** | **NO** | **CONDITION:** | **YES** | **NO** | **CONDITION:** | **YES** | **NO** |
| **BLEEDING OR OTHER BLOOD DISORDER** |  |  | **EPILEPSY/SEIZURE** |  |  | **CATARACTS** |  |  |
| **OPEN WOUND/SUTURED CUT** |  |  | **BLURRED VISION** |  |  | **DIABETES** |  |  |
| **HIGH TEMPERATURE/PYREXIA** |  |  | **HEARING LOSS** |  |  | **FAINTING** |  |  |
| **HEADACHES/MIGRAINES** |  |  | **BALANCE PROBLEMS** |  |  | **DIZZINESS** |  |  |
| **HIGH BLOOD PRESSURE** |  |  | **ASTHMA/BRONCHITIS** |  |  | **HERNIA** |  |  |
| **ANY HEART CONDITION** |  |  | **RECURRENT NECK PAIN** |  |  | **HIV** |  |  |
| **CHEST TRAUMA/RIB FRACTURE** |  |  | **RECURRENT BACK PAIN** |  |  | **HEPATITIS** |  |  |
| **CHRONIC OR ACUTE INFECTIOUS DISEASE** |  |  | **MENTAL ILLNESS** |  |  | **PREGNANCY** |  |  |

1. **ARE YOU OVER THE AGE OF 35? YES: [ ]  NO: [ ]**
2. **HAVE YOU HAD A FIGHT THAT ENDED IN KO OR RSC-H IN THE PAST 6 MONTHS? YES: [ ]  NO: [ ]**
3. **HAVE YOU EVER TESTED POSITIVE WITH WADA (WORLD ANTI-DOPING AGENCY)? YES:** **[ ]  NO: [ ]**
4. **ARE YOU CURRENTLY TAKING ANY MEDICATION? YES: [ ]  NO: [ ]
\*IF YES, PLEASE LIST ENSURE THAT YOU HAVE SUBMITTED A TUE FORM**
5. **HAVE YOU HAD ANY TYPE OF SURGERY IN THE PAST 6 MONTHS? YES: [ ]  NO: [ ]**
6. **HAVE YOU NEEDED IN-PATIENT TREATMENT IN A HOSPITAL IN THE LAST 6 MONTHS? YES: [ ]  NO: [ ]**
7. **HAVE YOU RECEIVED TREATMENT FOR A BONE FRACTURE, FISSURE OR DISLOCATION IN THE LAST 6 MONTHS? YES: [ ]  NO: [ ]**
8. **DO YOU NORMALLY WEAR EYE GLASSES OR CONTACT LENSES? YES: [ ]  NO: [ ]**
9. **HAVE YOU EVER HAD BACK OR SPINAL SURGERY? YES: [ ]  NO: [ ]**

 **PLEASE BE AWARE IF YOU ARE OVER 17 LABORATORY BLOOD TESTS RESULTS for HIV antibody & HBV (Hepatitis B Surface Antigen) & HCV (Hepatitis C Antibody) must be submitted with this form on the letterhead of the laboratory that administered the tests. The blood tests must be taken within 6 months prior to the date of competition. Females must also submit a pregnancy test.**

**MEDICAL HISTORY STATEMENT** *I have completed this medical history questionnaire and answered it truthfully and to the best of my knowledge. I am prepared to answer questions from the International Federation of Muaythai Amateur (including athletic trainers, nurses, consultants, coaches, and coordinators) and general practitioners concerning this medical history and medical conditions. I affirm also that I do not suffer from any disability, injury, condition, or complaint that I have not disclosed on this form. I further recognize the importance of fully and accurately disclosing my physical conditions, past and present, to International Federation of Muaythai Amateur.*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_
FIGHTER SIGNATURE DATE**

**MEDICAL DOCTOR EXAMINATION & APPROVAL:**

*The applicant’s medical fitness for the contact ring sport of Muaythai has been evaluated by physical examination and, if required (at the discretion of the attending physician) by the use of radiology and laboratory facilities.*

*This is to certify that ………………………………………………………………………………is in good physical condition and not suffering from any injury, infection or disability liable to affect his capacity to box in the competitions of the full contact sport of Muaythai.*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_
PHYSICIAN SIGNATURE DATE**

**CLINIC ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TEL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**