

**MEDICAL HISTORY BY FIGHTER**

PASCUA YAQUI TRIBE                      7777 S. CAMINO HUIVISIM BLDG. C  
ATHLETIC COMMISSION                      TUCSON, ARIZONA 85757

FOR OFFICAL USE ONLY

FED. I.D.

PYTAC I.D.

**SECTION ONE-FIGHTER INFORMATION**

Name:	Ring Name:
Federal I.D.:	Age:

**SECTION TWO-MEDICAL HISTORY**

1) Date of last bout:	Results: <input type="checkbox"/> Won <input type="checkbox"/> Lost <input type="checkbox"/> Draw <input type="checkbox"/> Other:
2) Have you ever been knocked unconscious?	If <b>YES</b> , when?
3) Are you <b>currently</b> suffering from any of the conditions noted below? a) Headaches: <input type="checkbox"/> Yes <input type="checkbox"/> No b) Blurring vision: <input type="checkbox"/> Yes <input type="checkbox"/> No c) Dizziness: <input type="checkbox"/> Yes <input type="checkbox"/> No	
4) Have you <b>recently</b> suffered from any of the injuries noted below? a) Injury while training for this bout: <input type="checkbox"/> Yes <input type="checkbox"/> No b) Neck injuries: <input type="checkbox"/> Yes <input type="checkbox"/> No c) Spinal injuries: <input type="checkbox"/> Yes <input type="checkbox"/> No	
5) Have you consulted a doctor for any medical condition while training for this bout? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>YES</b> , please explain why?	
6) Have you been ill in any manner since your last examination? <input type="checkbox"/> Yes <input type="checkbox"/> No	
7) Have you suffered from any accident or injury while training for this bout? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8) Have you contracted any type of "communicable disease" that maybe harmful to you or to others: <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>YES</b> , please explain:	
9) Do you wish to provide any information regarding any current medical conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>YES</b> , state information:	
10) Have you taken any prescribed medication within the last three weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>YES</b> , please explain:	
11) Have you taken any type of drugs within the last three weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No	
12) Do you wear contact lenses: <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>YES</b> , do you wear <input type="checkbox"/> Hard or <input type="checkbox"/> Soft	

**I hereby certify to the best of my knowledge and belief the above statements are true and correct. I also, realize that any deliberate misstatement will subject me to disciplinary actions by the Pascua Yaqui Athletic Commission.**

\_\_\_\_\_  
**Signature of Fighter**

\_\_\_\_\_  
**Date:**