



PRE-FIGHT OPHTHALMOLOGIC EVALUATION FORM

NAME: _____ EXAM DATE:

ADDRESS:

CITY: _____ STATE: _____ COUNTRY:

PHONE: _____ DATE OF BIRTH:

HISTORY

HAS THE APPLICANT EVER HAD ANY OF THE FOLLOWING CONDITIONS?

1) BLURRED VISION ? YES NO

2) SURGICAL EYE PROCEDURES? YES NO

IF YES, PLEASE EXPLAIN:

3) SIGNIFICANT EYE PROBLEM OR INJURY? YES NO

IF YES, PLEASE EXPLAIN:

4) EYE DISEASE? YES NO

IF YES, PLEASE EXPLAIN:

5) DETACHED RETINA? YES NO

IF YES, PLEASE EXPLAIN:

6) LASIK, RK OR PRK CORRECTIVE PROCEDURE?

YES

NO

IF YES, PLEASE EXPLAIN:

7) RECENT EYE INJURY?

YES

NO

IF YES, PLEASE EXPLAIN:

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Name: _____

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OPHTHALMOLOGIC EXAMINATION:

VISION: OD: ____/____ OS: ____/____ OU: ____/____ CORRECTED
UNCORRECTED

IF CORRECTED, BEST UNCORRECTED VISION: OD: ____/____ OS: ____/____ OU:
____/____

SLIT LAMP EXAM: OD: NORMAL ABNORMAL OS: NORMAL
ABNORMAL

DILATED PUPIL: OD: NORMAL ABNORMAL OS: NORMAL
ABNORMAL

LIGHT REFLEW: OD: NORMAL ABNORMAL OS: NORMAL
ABNORMAL

ACCOMMODATION RELEX: OD: NORMAL ABNORMAL OS: NORMAL
ABNORMAL

FUNDI EXAM: OD: NORMAL ABNORMAL OS: NORMAL
ABNORMAL

DISC: OD: NORMAL ABNORMAL OS: NORMAL
ABNORMAL

MACULAR: OD: NORMAL ABNORMAL OS: NORMAL
ABNORMAL

CATARACTS: OD: PRESENT ABSENT OS: PRESENT ABSENT

MOTILITY: OD: NORMAL ABNORMAL OS: NORMAL
ABNORMAL

BINOCULAR VISION: OD: NORMAL ABNORMAL OS: NORMAL
ABNORMAL

NYSTAGMUS: YES: _____ NO: _____ INTRAOCULAR PRESSURE: OD: _____
OS: _____

COMMENTS:

THE FIGHTER: IS IS NOT MEDICALLY CLEARED TO PARTICIPATE

Physicians Name:

Physician Signature:

Address: _____ City:

State: _____ Country: _____ Zip:

Phone: _____ Fax:
