



PRE-FIGHT OPHTHALOMOGIC 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: _____



**Association of
Boxing Commissions
and Combative Sports**

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OPHALMOLOGIC 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 REFLEX: 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:** _____