ANNUAL PHYSICAL EXAMINATION FORM

Massachusetts Department of Mental Retardation

Name:					**Date:**	
Vital Signs:	Ht	Wt	T°	BP	P	R
General Appearance:						
Skin:						
HEENT: Head						
Eyes/Vision Screen						
Ears/Hearing Screen						
Mouth/Throat						
Neck:						
Chest:						
Breast:						
Heart:						
Lungs:						
Abdomen:						
Genitalia: GYN/Testicular Exam						
Rectum:						
Musculoskeletal: Back/Spine						
Extremities						
Lymph Nodes:						
Circulatory:						
Neurologic: Cranial Nerves						
Reflexes						
Sensory						
Motor						
Cognitive						
Other:						

HC Provider Signature: _____

ANNUAL PHYSICAL EXAMINATION FORM

Addendum to Massachusetts Department of Mental Retardation Form
Habilitation Assistance Corporation

Name:		**Date:**	
		Yes	No
Have current medications been reviewed and continue to be clinically indicated?			
Is there any physical activity in which this person should not engage?			
If Yes, what?			
Are there any dietary restrictions for this person?			
If Yes, what?			
Please list all allergies:			
Do you approve of the following health club equipment?		Yes	No
Upright Stationary Bicycle			
Upright Stairstepper			
Recumbent Bicycle			
Pool/Aquatics			
Treadmill			
Universal			
Recumbent Stairstepper			
Elliptical			
		Yes	No
Do you approve day habilitation services for this individual?			

HAC Rev: 9-06, 4-04