ANNUAL PHYSICAL EXAMINATION FORM – PAGE 1 OF 2

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 – PAGE 2 OF 2

Addendum to Massachusetts Department of Mental Retardation Form
Habilitation Assistance Corporation

Patient Name: Date:

DO YOU APPROVE DAY HABILITATION SERVICES FOR THIS INDIVIDUAL?

YES **NO**

PLEASE LIST ALL ALLERGIES:

ARE THERE ANY DIETARY RESTRICTIONS FOR THIS PERSON?

YES **NO**

If yes, what are the dietary restrictions?

DO YOU APPROVE THE FOLLOWING HEALTH CLUB EQUIPMENT?

Upright Stationary Bicycle	YES	NO
Upright Stairstepper	YES	NO
Recumbent Bicycle	YES	NO
Pool/Aquatics	YES	NO

Treadmill	YES	NO
Universal	YES	NO
Recumbent Stairstepper	YES	NO
Elliptical	YES	NO

LIST ANY PHYSICAL ACTIVITY IN WHICH THIS PERSON SHOULD NOT ENGAGE:

HAVE CURRENT MEDICATIONS BEEN REVIEWED AND CONTINUE TO BE CLINICALLY INDICATED?

YES **NO**

HC PROVIDER SIGNATURE _____ **DATE**_____