

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: _____