ANNUAL PHYSICAL EXAMINATION FORM

Massachusetts Department of Developmental Services

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: _____