

Report of Physical or Mental Examination

PLEASE RETURN TO:

Texas Health and Human Services Commission

Attn:

The person identified below has applied for TANF, medical assistance or employment services. From your medical report, we need to determine the person's eligibility based on disability. Please perform a basic physical examination. **This does not include X-rays, diagnostic tests, hospitalization or treatment.**

Patient Name			Date of Birth	
Address				
Case Name	Case No.	Category	App. No.	Soc. Sec. No.
Eligibility Specialist	BJN	Mail Code	Medical Authorization Date	

TO BE COMPLETED BY EXAMINING PHYSICIAN

Medical History: _____

Height	Weight	Blood Pressure	Pulse	General Appearance	Head, Scalp
Ears	Hearing ▶ Rt. Lt.		Nose	Throat	Mouth

Visual Acuity:	WITHOUT GLASSES		WITH GLASSES	
	Distance (20 ft.)	Near (14 in.)	Distance (20 ft.)	Near (14 in.)
RIGHT EYE				
LEFT EYE				

Field of Vision
 Is there any limitation in the field of vision? **Right Eye:** Yes No **Left Eye:** Yes No

Neck: _____

Chest: _____

Cardiovascular System											
Cardiac Status		<input type="checkbox"/> Uncompromised	<input type="checkbox"/> Slightly Compromised	<input type="checkbox"/> Moderately Compromised	<input type="checkbox"/> Severely Compromised	Prognosis		<input type="checkbox"/> Good	<input type="checkbox"/> Good With Therapy	<input type="checkbox"/> Fair With Therapy	<input type="checkbox"/> Guarded Despite Therapy

Vascular System: _____

Gastrointestinal: _____

Genitourinary: _____

