

Medical Go Bag Checklist

Documents

- Medical History Document (included)
- Copy of Identification: Driver's license, etc
- Copy of Health Insurance Card
- Copy of Advance Directive or Power of Attorney
- Pet Care Information Document (included)

Comfort

- Dentures carrying case
- Assistive device, if applicable
- Favorite book
- Scrabble, Sudoku, games
- Cellphone/iPad/Tablet and chargers
- Paper and pen
- Picture of loved ones
- Comfort item from home
- Nonslip slippers/slip-on shoes

Extras

- Extra shirt, pants and underwear
- Spare house key
- Spare hearing aids with batteries
- Spare pair of glasses or contacts
- Foods, if applicable
- Refillable water bottle



Printable Bag Loop

Print and cut out with scissors.

Attach to Medical Go Bag.



Belongs to: _____



Medical Go Bag



Contains Important Medical Necessities - Keep On Person



Belongs to: _____



Medical Go Bag



Contains Important Medical Necessities - Keep On Person



Belongs to: _____



Medical Go Bag



Contains Important Medical Necessities - Keep On Person

Medical History

Patient Information		Preferred language:																																		
Name:		DOB:		Gender:																																
Address			Phone																																	
Emergency Contact #1																																				
Name		Relationship		Phone																																
Emergency Contact #2																																				
Name		Relationship		Phone																																
Emergency Contact #3																																				
Name		Relationship		Phone																																
Insurance Information																																				
Insurance Provider			Policy number																																	
Personal History (Check all that apply)																																				
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Other medical issues:																																				
Treatments/Medications																																				
Name(s)	Dosage(s)	Frequency	Purpose	Note(s)																																

Treatments/Medications

Name(s)	Dosage(s)	Frequency	Purpose	Note(s)

Dietary restrictions:	Allergies:
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Family History (Check all that apply)

<input type="checkbox"/> No known family history of medical conditions <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Mental Health Conditions (Depression, Anxiety, etc.) <input type="checkbox"/> Autoimmune Diseases <input type="checkbox"/> Other:
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Name of Primary Care Provider (PCP): Phone number and address of PCP:	Additional health information:
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Surgeries/Procedures (with dates):

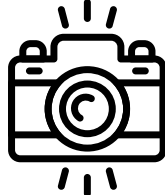
Name of pharmacy:

Phone number of pharmacy:

Address of pharmacy:

Please use this page to share any other important patient information for the medical team:

Care information for Pet

Pet's Name:		 <p>Add a picture of your pet here</p>
Sex:	Age:	
Breed:		
Coloring:		

Food Info

Please include all food information relevant to your pet below. Including food brand, amount and frequency of meals below.

Potty Break

Please include all information relevant to your pet's bathroom business below.

Additional info

Please include any additional information about your pet, such as outside time and/or medication information below. Vet information, such as, name, address, phone number.

Pet's contact person and phone number:

