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MAPFRE | ASSISTANCE
L'EUROPÉENNE
d'assurances voyages

MEDICAL QUESTIONNAIRE

Dossier N° :

In accordance with the terms of your contract, please ask the doctor to complete the following questionnaire and return it to our medical department in a closed envelope.

Patient identification

Last name : …….. First name : ..……

Medical information

Your patient's medical history …….
……..

……..

Your patient's usual treatment:……
……..

Concerning the illness responsible for cancellation

Nature of the illness:……..

……

Date of first symptoms or signs :……

Treatment prescribed :……

……

Date of diagnosis :……...

Current treatment:……

Examinations requested:……

……..

ATTENDING PHYSICIAN'S STAMP

Date and signature