Name: _____ Date: _____

What do you have? I have a...

D I Z Z Y Z Z V C S P A D M M O Z
N L T G Z E H C A H T O O T B C Q
Y Y V T J L S T O M A C H A C H E
O I Y E I I S O R E T H R O A T R
H F U Z F M U X Z C C B Y G H R E
B L I R E Z O I S P U E N G G X V
R X J N T R C V B A S I V H U K E
J A E S U A N W Z O Z C W T O I F
J E Z Q I B G W N E E A R A C H E
Y Z K U R K G Y E N S A A S S F L
O H H G P D N N O E H C A D A E H
N G U Q N N S O P M E F J J A Z G
F J E H U I P M A R C Q L S C J Y
F Y S R B F G U C H E S T P A I N
L A O P E K F N V A E H R R A I D
R K F J B Q P U I G B C O L D I R
B M M U B C G D T R U Y J U N O Q

sore throat
toothache
earache
vomit
rash
stomachache
diarrhea
ringing
dizzy
cold
chest pain
sneezing
nausea
fever
runny nose
headache
cramp
cough