Name: _____ Date: _____

What's the matter? What do you have? What hurts? How do you feel?

V Y E L B O W P E C

P Z E S K H A N D O

L E G C N R X M I U

X H Z O E J U F S G

U E T L E T O O T H

E A R D B A C K F D

I D F O O T A I E R

N A U S E O U S V H

C Q U Y E Y E S E X

S S T O M A C H R Q

nauseous
fever
cold
knee

stomach
tooth
eyes
ear

cough
hand
foot
leg

elbow
back
head