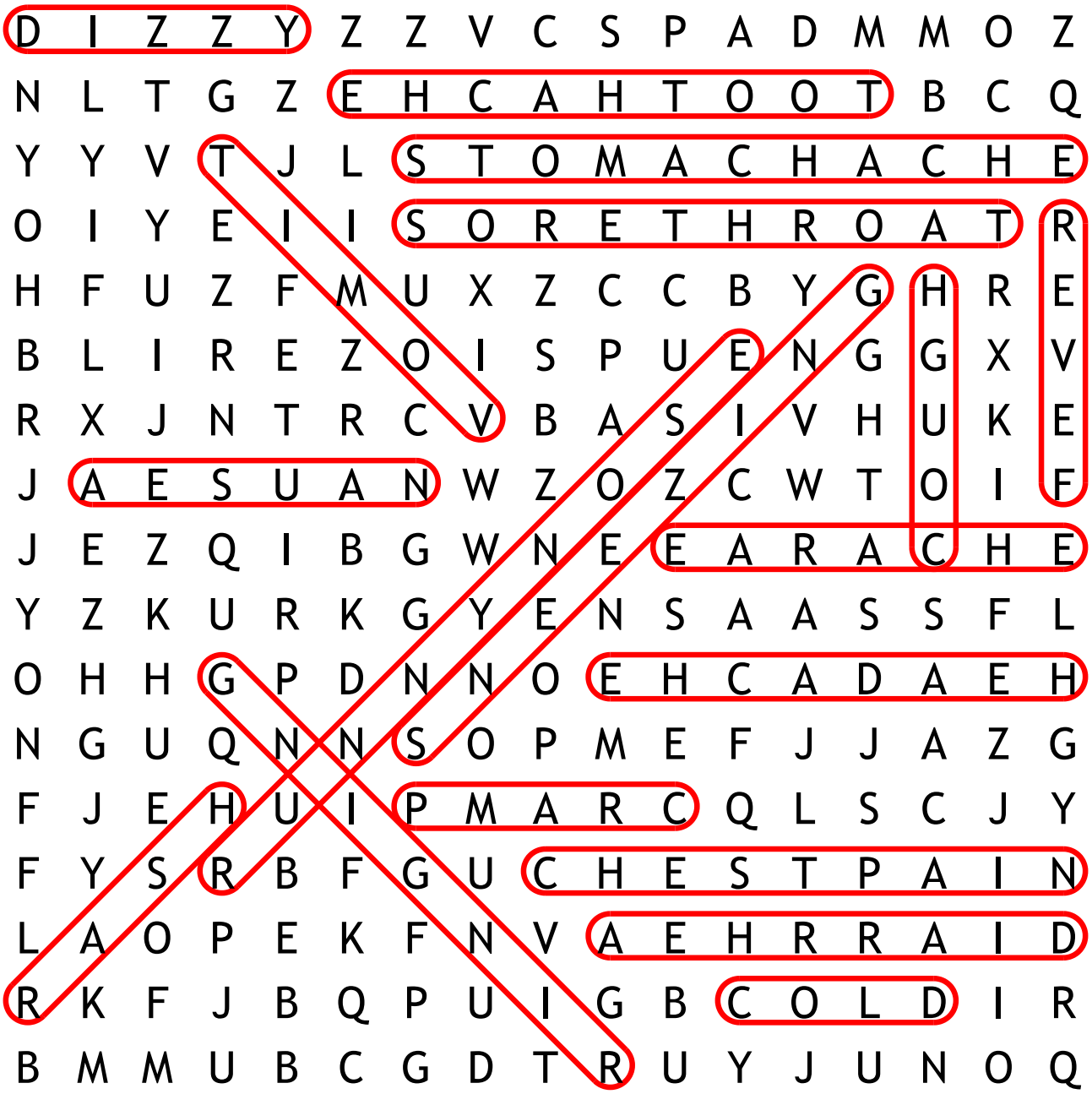
Name: _____ Date: _____

What do you have? I have a...



sore throat
toothache
earache
vomit
rash

stomachache
diarrhea
ringing
dizzy
cold

chest pain
sneezing
nausea
fever

runny nose
headache
cramp
cough