

Name: \_\_\_\_\_

Date: \_\_\_\_\_

# Ailments and Injuries



1. I have a \_\_\_\_\_.



2. I feel \_\_\_\_\_.



3. I am \_\_\_\_\_.



4. I have an \_\_\_\_\_.



## 5. I feel \_\_\_\_\_.



## 6. I have a

headache dizzy sick insect bite

cold nauseous