Select affected body part(s) from list below:

|  |  |  |
| --- | --- | --- |
| **FRONT of BODY** | | |
| **Left Side of Body** | | **Right Side of Body** |
|  | HEAD | |
|  | EYE | |
|  | EAR | |
|  | NOSE | |
|  | FACE | |
|  | JAW | |
|  | FOREHEAD | |
|  | EYEBROW | |
|  | CHEEK | |
|  | MOUTH | |
|  | CHIN | |
|  | SHOULDER | |
|  | ARMPIT | |
|  | CHEST | |
|  | FOREARM | |
|  | WRIST | |
|  | ABDOMEN | |
|  | HAND | |
|  | THUMB | |
|  | INDEX FINGER | |
|  | MIDDLE FINGER | |
|  | RING FINGER | |
|  | LITTLE FINGER | |
|  | HIP | |
|  | THIGH | |
|  | KNEE | |
|  | LOWER LEG | |
|  | ANKLE | |
|  | FOOT | |
|  | TOE(s) | |

