



Melody
AUDIOLOGY LLC

Dr. Hannah Formella Zdroik
Gold Certified Music Audiologist, CCC-A
Dr.hannah@melodyaudiologyllc.com
Melodyaudiologyllc.com

Music Industry Case History

Date:

First & Last Name:

Date of Birth:

Address:

Age:

City

State

Zip

Phone:

Email:

YOUR MUSIC JOURNEY

Name of Bands/Groups:

Occupation & Type of Work (Studio, Touring, etc.)

Genres:

List Instruments You Play:

Are you a vocalist? YES NO

Gig Lengths:

How many years have you been in the industry?

How long has it been loud?

Do you play
Professionally As a Hobby

EXPOSURE

How many days per week are you exposed?

How many hours per week are you exposed?

Are you exposed to loud sound in your
RIGHT EAR LEFT EAR BOTH EQUALLY

Have you experienced acoustic trauma
(Ex: Loud Feedback)?

YES NO

If yes, please explain:

How many hours has it been since you've
been exposed to loud sounds?

HEARING PROTECTION & IEMs

Do you wear hearing protection when
exposed to loud music?

YES NO

If yes, what percentage of the time?

How many years have you been wearing
them?

What kind? _____

CUSTOM UNIVERSALLY FIT FOAM OTHER

If they are filtered, which strength?

9 dB 15 dB 25 dB

If you don't wear hearing protection, would
you consider it?

YES NO

Do you feel like your work environment is:
__Too Loud __Loud Enough __Not Loud

Do you wear headphones or earbuds?

YES NO

Do you wear In-Ear Monitors?

YES NO

Do you consider In-Ear Monitors to be a
safety device?

YES NO

OTOLOGIC HISTORY

Do your ears ring after a gig?

YES NO

Do you have ringing in your ears?
CONSTANTLY COMES AND GOES

Does it interfere with your sleep?
YES NO

Do you have a family history of hearing loss?
YES NO

Is it from birth?
YES NO

Do you have a history of ear infections?
YES NO

Have you ever had any ear surgeries?
YES NO

If yes, explain:

Do you take Aspirin?

YES NO

Are you a smoker or former smoker?
YES NO

Do you drink caffeine?
YES NO

How much?

Do you have any of the following?
Check all that apply.

- Ringing, Buzzing, Hissing Distortion
 Pitch Perception Difficulties Sound Sensitivity

Do you have any of the following?
Check all that apply.

- Hearing Loss Syphilis
 Hearing Disease Meningitis
 Dizziness Tuberculosis
 Stroke Scarlet Fever
 Diabetes Anxiety
 Kidney Disease Depression
 High Blood Pressure Medication via IV
 Chemotherapy Other

RECREATIONAL NOISE EXPOSURE

Do you work in a noisy environment, other
than music?
YES NO

Do you ride a motorcycle?
YES NO

Are you exposed to gunfire?
YES NO

Do you use powertools?
YES NO

Do you use powertools?
YES NO

Do you use hearing protection during these
activities?
YES NO

Do you have difficulty hearing in quiet?
YES NO

Do you have difficulty hearing in background
noise?
YES NO

When was your last hearing evaluation?

Are you concerned about the confidentiality of
your hearing test?
 YES NO

Do you feel that regular hearing tests are important
considering your level of noise exposure?
YES NO MAYBE NOT SURE

Are you embarrassed to wear earplugs?
YES NO

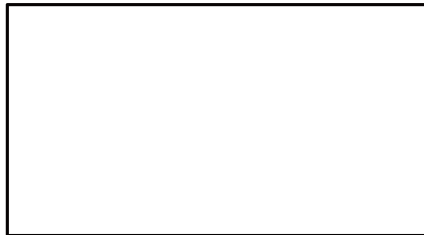
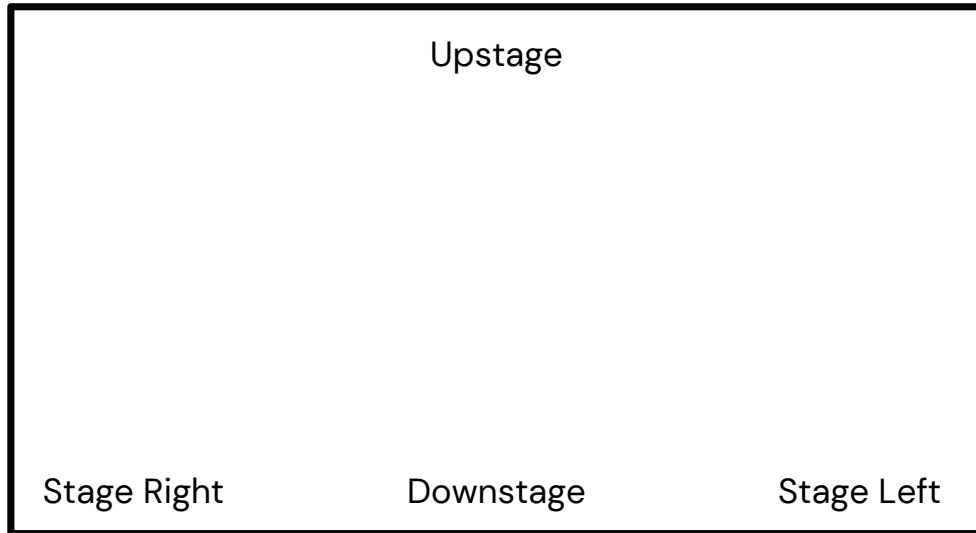
AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Hannah Formella Zdroik to
release any medical or incidental information that
may be necessary for either medical care or in
processing applications for financial benefit.

✕ _____

PERFORMANCE POSITIONING

Where do you usually stand or sit in relation to other musicians? Please illustrate below.



FOH

If you would like Melody Audiology LLC to follow you on social media to stay connected & share your music, please leave your social handles below:

I allow Dr. Hannah Formella Zdroik to take pictures/videos for social media promotion.

YES

NO

