Hearing Solutions in the Triangle

# MUSICIAN'S PROFILE

| | | | | | |
|---|---|---|---|---|---|
| **Last Name** | | **First Name** | | | |
| **Date** | | **Home Phone** | | | |
| **Address** | | | | | |
| **City** | | **State** | | **Zip** | |
| **Email Address** | | **Date of Birth** | | | |
| **Employer** | | | | | |

| | | |
|---|---|---|
| **Name Of Bands (if any)** | | |
| **Type of Work** | | |
| **What instruments do you play?** | | **Vocalist?** Yes ☐ No ☐ |

## MEDICAL HISTORY (please check all that apply)

| | | | | |
|---|---|---|---|---|
| **Family History of Hearing Loss** ☐ | **Tinnitus**: Right: ☐ Left ☐ Both ears: ☐ | **Dizziness** ☐ | **Vision Problems** ☐ | **Stroke** ☐ |
| **Hypertension** ☐ | **Diabetes** ☐ | **High Blood Pressure** ☐ | **Cancer** ☐ When: Treatment:: _____ | **Other** ☐ |
| **Live threatening antibiotics?** **Yes** ☐ **No** ☐ | **Kidney Disease** ☐ | **Heart Disease** ☐ | **Hearing Loss** ☐ | **Head Injury** ☐ When: |
| **History of Ear Infections?** Yes ☐ No ☐ **Surgeries on your ears?** Yes ☐ No ☐ Explain: _____ | | | | |
| Do/did you take aspirin? Yes ☐ No ☐ How much? | Do/did you smoke tobacco? Yes ☐ No ☐ How much? | Do/did you drink alcohol? Yes ☐ No ☐ How much? | Do/did you drink caffeine? Yes ☐ No ☐ How much? | |

# NOISE EXPOSURE HISTORY (circle all that apply and indicate (+/-) whether or not hearing protection devices used)

| | | |
|---|---|---|
| **Noise exposure at work** | **Recreational noise exposure** | **Guns, Target Shooting** |
| **Power tools** | **Farm equipment** | **Military service** |
| **Noisy Hobbies** | **Engine Noise** | |
| **When was your last hearing test?** _____ | | |

# MUSIC EXPOSURE (check all that apply)

| | | |
|---|---|---|
| **How long have you been exposed to music?** | **How long has it been loud?** _____ | **Do you play?** Professionally ☐ Hobby ☐ |
| **How many hours since you've been exposed to loud sounds today?**_____ | | |
| **How many hours since you've been exposed to loud sounds today?** _____ | **Have you experienced any acoustic trauma due to playing ( i.e. very loud feedback)?** Yes ☐ No ☐ **Explain:** _____ | |
| **Are you exposed to noise in :** Right Ear ☐ Left Ear ☐ Both Equally ☐ | **How many hours per week are you exposed (average)?** _____ | |
| **Do you wear Hearing Protection when you're exposed to loud music?** Yes ☐ No ☐ **What percent of the time?** 25% ☐ 50% ☐ 75% ☐ 100% ☐ **How many years?** _____ **What type?**_____ | | |
| **Do your ears ring after exposure?** Always ☐ Sometimes ☐ Never ☐ Other symptoms ☐ | **Do you consider your work environment?** Too loud ☐ Loud enough ☐ Not Loud ☐ | |
| **Do you wear studio phones and/or personal stereo headphones?** Yes ☐ No ☐ | **Do you wear personal In-Ear Monitors?** Yes ☐ No ☐ Right / Left / Both | |

**Illustrate your position relative to other musicians below:**

STAGE RIGHT STAGE LEFT

By signing below, you allow ***Hearing Solutions in the Triangle, PLLC*** to release all medical information to your insurance carrier(s). You also agree to accept financial responsibility for all charges for services rendered. This release is valid for life but may be revoked in writing at any time.

Signature of Patient or Guarantor

_____

Date:

_____