Ian Wert
September 23rd, 2024
Psychiatry Rotation H&P 2

Name: J.W
Age: 18
Address: Great Neck, NY
Date/Time: 09/18/24
Location: Queens Hospital Psych CPEP
Source of Information: Patient & Patient's mother (Mandarin interpreter #39575737)
Source of Referral: Primary care physician
Reliability: Reliable
Mode of Transport: EMS from primary care office

Chief complaint: Patient feels depressed and had suicide attempt 1 week ago

HPI:
Pt is an 18-year-old mandarin speaking Chinese male, domiciled with his parents with a pphx of major depressive disorder with hx of previous suicidal behavior (cutting self-2-3 years ago) and no pmhx. Patient was BIBEMS activated by his primary care physician after patient had a suicide attempt on 9/10. Patient denies any current medications, denies loss of appetite, denies poor sleep, and denies substance abuse. Upon evaluation of the patient, he was noted to be sad appearing, with a blunted affect. Patient admitted to intentional overdose by ingesting 87 pills of (doxylamine succinate 25mg) on 9/10. Patient reports that he has many stressors in his life including the pressure to do well in school, parents getting a divorce, and financial hardship. Patient admits to feeling depressed, hopeless at times, however, denies active suicidal and homicidal ideations. Patient reports intermittent non-command auditory voices in the last 2 to 3 years. Patient states that the voices are usually familiar male and female voices of his friends in China and the USA. Patient reports voices encourage him to study more, eat more, and he denies command auditory hallucinations to hurt himself or other people. Multiple attempts were made to speak with patients' mother however unsuccessful. Patient continues to be a danger to himself due to multiple stressors, recent suicide attempt, hx of suicidal behavior (cutting 2-3 years ago) and feeling hopeless.

Past Medical History:
Major Depressive Disorder

Past Surgical History:
Denies

Medications:
Denies

Allergies:
No Known Allergies

Family History:
Mother - alive and well
Father - alive and well

Social History:
18 y/o male living in a house in Great Neck, NY
Smoking: Never
Alcohol: Never
Recreational Drugs: Never
Travel: Denies Recent travel
Marital Status: Single
Occupation: Student
Diet: Reports a well balanced diet
Exercise: Denies
Sleep: 5-6 hours of sleep nightly

ROS:
General: Denies fever, chills, diaphoresis, weakness, fatigue
Skin/hair/nails: Denies discoloration, changes in hair distribution/texture
Head: Denies headache, dizziness, recent trauma
Eyes: Denies blurry vision, decreased vision
Ears: Denies tinnitus, pain
Nose: Denies discharge, epistaxis
Mouth/throat: Denies bleeding gums, mouth ulcers
Neck: Denies localized swelling, stiffness, decreased range of motion
Breast: Denies lumps, nipple discharge, pain
Respiratory: Denies SOB, cough, hemoptysis
Cardiovascular: Denies chest pain, palpitations, feet/ankle edema
Gastrointestinal: Denies abdominal pain, change in appetite, nausea, vomiting, diarrhea, constipation
Genitourinary: Denies dysuria, hematuria, flank pain
Nervous system: Denies headache, seizures, LOC, weakness, loss of strength, changes in cognition, mental status
Musculoskeletal: Denies any muscle/joint pain, swelling, numbness, weakness.
Endocrine: Denies palpitations, heat or cold intolerance
Hematologic: Denies anemia, DVT/PE.
Psychiatric: Reports history of major depressive disorder. Admits to recent suicidal attempt, recent feelings of distress due to school and parents' divorce.

Physical Exam:

BP 115/70
HR 84
RR 18
Temp 98.5F
SPO2 99%
Wt. 63.1 kg
Ht 167cm
BMI 22.6 kg/m^2
Patient is a 18 year old male who appears his stated age. Patient is alert to person, place, and time and appears in no acute distress.

Mental Status Exam:
GENERAL:

1. Appearance: J.W is a Chinese male with black hair. He has no scars on his face or hands. He appears well groomed. Patient is in no apparent distress.
2. Behavior and Psychomotor Activity: J.W spoke in normal rhythm but with a low tone.
3. Attitude Towards Examiner: J.W was cooperative and maintained appropriate eye conduct.

SENSORIUM AND COGNITION:

1. Alertness and Consciousness: Pt was alert and conscious.
2. Orientation: Pt was oriented to the time of day, the place and the date.
3. Concentration and Attention: Pt demonstrated appropriate concentration and attention. He provided relevant responses to all questions.
4. Capacity to Read and Write: Pt can read and write.
5. Abstract Thinking: Pt clarified thoughts and displayed intact abstract thinking.
6. Memory: Remote and recent memory were intact. Remembered all events leading to ED visit.
7. Fund of Information and Knowledge: Pt's intellectual performance was consistent with his level of education.

MOOD AND AFFECT:

1. Mood: Patient was sad, depressed, and appeared to have minimal energy.
2. Affect: Blunted affect
3. Appropriateness: Mood and affect consistent with topic discussed. No outburst of emotions.

MOTOR:

1. Speech: Pt's speech was normal in tone, slow speed, clear.
2. Eye Contact: Pt made adequate eye contact with the PA and students.
3. Body Movements: No psychomotor abnormalities observed. Pt has no extremity tremors or facial tics. All movements were fluid.

REASONING AND CONTROL:

1. Impulse Control: Pt's impulse control was satisfactory. He did not have any acute suicidal ideations/plan.
2. Judgment: Limited due to depressive state and previous suicide attempts.

3. Insight: Pt had good insight to his psychiatric condition. He was aware of why EMS was called and expressed the desire for help.

Differential Diagnosis:

1. Major Depressive Disorder
    - The patient states that he has been feeling depressed and hopeless at times. Patient has a previous history of suicidal behavior (cutting) and more recently a suicidal attempt ingesting 87 sleeping pills. Patient mentions many stressors including college, parents divorce, and parents pressure to succeed. Patient also presented sad appearing with a blunted affect.

2. Adjustment Disorder with depression.
    - Patient had many recent changes going on in his life within 3 months that could be leading to his depressive state and suicidal attempt. This included him starting college, and his parents getting divorced.

3. Schizoaffective Disorder – Depressive Type.
    - Patient reports a history of intermittent auditory hallucinations in the past of his friends telling him to eat more, and study harder. He also has symptoms of depression as he states he feels depressed and hopeless and also presents sad with a blunted affect. Patient also had a history of previous self harm and a more recent suicide attempt.

Assessment:

- J.W is a 18 y/o Chinese male with a psychiatric history of major depressive disorder who lives with his parents BIBEMS activated by his primary care physician for a suicidal attempt that he reported happened a week prior to the patients visit. Patient presents sad, with blunted affect. Patient does not have any acute suicidal and homicidal ideations. Patient does report many stressors in his life as he started college recently, and his parents are getting divorced. Patient is in need for further stabilization as he still presents as a risk to himself. History and evaluation is most consistent with major depressive disorder.

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Plan:

- Patient to be started on sertraline 25mg , orally, daily
- Patient to be admitted to unit P5 for further stabilization and observation regarding suicide attempt
- Patient to observed Q15 to maintain patient safety and to monitor for any behavioral changes
- Encourage participation in inpatient services such as individual and group therapy
- Plan for discharge within 2 weeks if patient mood stabilized, no suicidal ideations exist, and adherence to treatment.
- Discuss and educate patient and family regarding resources and concerning signs and symptoms of patients condition.