Psychiatry H&P

CC: 22 yo male admitted for suicide attempt.

HPI: The patient was found unconscious, but breathing, in his room last night by his roommate. He/she was taken to the ER where he was found to be positive for benzodiazepenes and opioids. The pills were obtained from his mother's medicine cabinet. He was stabilized and then care was transferred to the psychiatry inpatient service. This is his first suicide attempt. He identifies that he first began struggling with "depressive" symptoms in his third year of college after a break-up of a long-term relationship. This was also influenced by a difficult college class schedule and worsening grades. After graduating from college the depression continued and has been worsened by the fact that he has had difficulty finding a job as an accountant, which is what his college training is in. Three days ago he had another break-up of a long-term relationship. The break-up was abrupt and very traumatic and ultimately was the final event that led to the suicide attempt. He believes the depressive symptoms have been episodic since their onset over two years ago, noting periods of improvement between depressive events.

His depressive symptoms include generally feeling down with anhedonia. He has had difficulty falling asleep for the past month. This is significantly decreasing his total sleep time and leading to daytime fatigue. He denies a recent change in appetite but does admit to poor concentration. Despite the recent suicide attempt he says that he really does not want to die. He says that his mother provides a good deal of emotional support but that she has been away for the past week on a business trip. He also identifies a few good friends who provide support.

He denies a known history of any medical or psychiatric disorders. He denies use of any illegal substances and only occasionally consumes alcohol. He denies a history of periods of excessive energy, racing thoughts, agitation, irritability, distractibility, or irresponsible activity. He admits to some excessive worrying at times but denies anxiety that interferes with daily life. There is no evidence of panic disorder. He denies any delusions or hallucinations. He does have a family history of depression in his mother.

Allergies: KNMA

Medications: None

Health Maintenance:

Exercise: none currently
Sleep: In bed for 8 hours but 6 hours of sleep on average
Diet: varied
Sexual activity: monogamous x 1 year, no history of STDs
Immunizations: up-to-date per patient

Social history: Works part-time at a coffee shop. Struggling financially. Lives in an apartment and has one roommate. Smokes and drinks only occasionally. No use of illegal substances. Mother lives in town and visits with him once or twice weekly. No contact with father who left when he was a young child.

Surgical history: tonsils and adenoids removed as a child.

Family history:

Mother: 51 yo. Depression treated with Prozac
Father: 54 yo. Unknown
Sister: died at age 10 in auto accident

ROS: Constitutional- As above. No fevers or weight changes.
Skin- No rashes, pruritis, or jaundice.
Head- No headaches or dizziness

Eyes- No vision changes or pain
Ears- No tinnitus or changes in hearing
Nose- No epistaxis, congestion, or rhinitis.
Mouth/Throat- No oral sores, dysphagia, dry mouth or hoarseness.
Neck- No pain or swelling.
Respiratory- No dyspnea, orthopnea, wheezing, or cough.
Cardiovascular- No palpitations, chest pain, or edema.
GI- No recent nausea, vomiting, diarrhea or constipation. No melena or hematochezia
GU- No dysuria, hematuria, nocturia, or dysparunia.
Endocrine- No history of diabetes or hypothyroidism. No history of heat or cold intolerance or changes in hair or skin. No polydipsia or polyuria.

Mental status exam:

Appearance- Patient is dressed in a hospital gown. Facial expressions are limited and primarily flat. He appears restricted in range of emotional expression.

Mood: He describes feeling down most of the time recently and being very "emotional." Mood is persistently depressed and worse in the mornings.

Affect: Primarily depressed and therefore congruent with stated mood. He does smile randomly when talking about his relationship with his mother.

Speech: Quality shows appropriate tone, volume but slowed at times. Speech is fluent, well organized, coherent, and logical.

Thought Content: He lacks obsessions or compulsions. Thoughts are absent of ruminations, indecision, or phobias. There are no thoughts of depersonalization, feelings of persecution, or somatic preoccupations. No delusions or hallucinations.

Cognitive Function:

Orientation- He is alert and oriented to person, place, and time.
Attention- spelled WORLD forward and backwards without difficulty.
Memory- was able to repeat "cat, ball, and sidewalk," and recall all three at five minutes. Additionally, was able to list his own birthplace and current address.
Language- Able to correctly name a pen and watch.
Abstraction- correctly interpreted two proverbs, "don't judge a book by its cover" and "don't count your chickens before they hatch.
Knowledge- was able to list all five great lakes
Judgment- stated that he would mail a sealed, addressed, and stamped envelope if he found one lying on the ground.
Insight- he was able to talk about his current situation and how he believes past events have influenced his current depressive state. Claims to no longer have any suicidal ideation. No homicidal ideation.

Physical Exam:

Vitals: T-98.2^{o}F, P-78, R-14, BP-125/85, Ht- 5'9" Wt- 165lbs BMI- 24.4
HEENT: Normocephalic, atraumatic head. Oral mucosa is dry but without lesions.
Neck: supple without cervical lymphadenopathy, no JVD, no thyroidomegaly or thyroid masses.
Cardiovascular: S1S2, RRR, no murmurs, no gallops. No lower extremity edema.
Lungs: Clear to auscultation. No wheezes, rhonchi, or crackles.
Skin: No Cyanosis. No lesions or rashes.

Assessment:

Axis I- Major depressive disorder, recurrent, without psychotic features

Axis II- None

Axis III- None

Axis IV- Recent break-up with significant other
Under-employed
Primary support (mother) temporarily out-of-town

Axis V- Global Assessment of Function score: 15-20.

Summary statement:

The patient is a 22 yo male who is admitted after a first-time suicide attempt using prescription medications. He has a history of major depressive disorder, which has never been treated. Current stressors include, struggling financially, being under-employed, and unable to find a job that matches his training. Additionally, patient recently went through a difficult break-up with his significant other. The patient has no other suicide plan.

Plan:

1) Patient will receive inpatient care for depression until suicidal ideation can be reassessed and risk of future attempts can be minimized. Patient will participate in daily group and individual classes. Expect at least 3-4 days of inpatient therapy.

2) We will draw the following labs: CBC, electrolytes, and TSH.

3) Patient will be started on fluoxetine 10mg daily. Outpatient monitoring of treatment will be established prior to, and continued on, after discharge.

4) Patient will meet with a case manager to coordinate both inpatient and outpatient care.