# SAMPLE HISTORY and PHYSICAL

History and Physical Examination of P.R.T.

Performed in Emergency Department, 3/19/06 2:00PM
Source of Information: Patient

**Identifying data**: Patient is a 24-year old single Caucasion woman, currently a full time student attending college of the Mainland, self referred to E.D. for evaluation of anxiety and low mood.

**CC**: "I just feel overwhelmed and can't take it anymore"

**HPI:** PRT is a 24-year-old woman who reports that she has had difficulties periodically with anxiety and low mood for a good part of her life since age 13.She has been treated in the past with 6 months of counseling (age 15) and sertraline 100mg qd (ages 16-23). Her current difficulties began 9 months ago following the ending of a 2 year relationship with man that she had hoped to marry. She reports that she has "never felt this badly" before and she doesn't know if she will recover. Her current symptoms include low mood most of the day, more days than not, decreased interest for most activities that she once enjoyed, both initial and terminal insomnia, decreased appetite with a 15 lb weight loss over the past 9 months, feelings of worthlessness, decreased energy, and marked feelings of anxiety but not panic attacks. Concentration is intact, but her other symptoms are making it very difficult for her to function adequately in school and she considering dropping her classes. She reports feelings of "not wanting to live" but denies active suicidal ideation—has no plans and states that even though she has had suicidal ideation when she was young (age 15) she would never do that now because of her parents. She denies any current or past symptoms of hallucinations, delusions, decreased need for sleep, pressured speech, grandiose ideations, flight of ideas, or excessive irritability. She states that she worries a great deal, primarily about her relationships, but does not believe that her worry is "excessive" or abnormal. She denies obsessive thoughts or compulsive rituals. She denies a history of significant trauma or abuse. After the onset of her current episode, Her psychiatrist, Dr. R. McDonald, tried switching her from her long time dosage of sertraline 100mg per day to escitalopram 10mg (6 week trial) , paroxetine (1 week trial- stopped due to side effects), and venlafaxine (started on 75mg 2 weeks ago), but none of these medication changes have had a significant change in her mood. She is becoming progressively more despondent, and wondering what other options are available. Her decision to come to the E.D. today was prompted by the fact that this upcoming weekend is the anniversary is their first date. She reports feeling overwhelmed with grief and does not know if she will ever find another relationship like this one again.

**Past Medical History:**
Illnesses: Patient has occasional migraine headaches for which she takes Excedrin Migraine
Hospitalizations: none
Surgeries: none
Allergies: no known drug allergies
Current medications: Venlafaxine 75mg po qd
Current physician: Sees Dr. R. McDonald for psychiatric meds
PCP is Ob/gyn physician, Dr. Sam Curry in Texas City- last visit was in 11/04

**Past Psychiatric History**

Patient first saw a counselor at age 15 for 6 months, with some relief of symptoms.
Meds: Sertraline 100mg qd ages 15-23, with considerable relief of symptoms until current episode
No hospitalizations
Diagnoses: unsure, except "anxiety and depression"
Suicidal gestures or attempts: none

**Family Psychiatric and Medical History**

Paternal grandfather abused etoh
Paternal grandmother suffered from depression
She doesn't believe there is any psychiatric problems in mother's family, but she is unsure
Sister also has anxiety, takes paroxetine
Reports both parents are generally healthy, although mother is overweight and was recently told she was "pre-diabetic"
Siblings (1 sister, age 28, 2 brothers, ages 26 and 22, are all healthy)

**Social history**
The patient was born in Norman, Oklahoma, the 3rd of 4 children with 1 older sister, an older brother and one younger brother. Her father is a C.P.A. and her mother stayed at home while she was growing up and currently works as an assistant in a veterinarian's office. She describes her relationship with her parents as warm, and reports that she is particularly close to her mother. She states that both her parents are relatively shy people, and have a small circle of close knit friends. They were active in their church (Methodist) and continue to be so. She used to enjoy going to church when she was young, but as she got older found it less meaningful and now rarely attends. She is uncomfortable around people she doesn't know well, and would rather stay home. She reports that she remembers little about her early childhood, but does not believe that there was anything remarkable about it. She "did ok" in elementary school, and was particularly close to one friend. Her difficulties first began in middle school when her family moved from Oklahoma to Texas and she felt "out of place" in her new school. She

reports that she was extremely shy and hated to be called on in class. She would blush easily, and would become “paralyzed” with anxiety when she was asked a question or required to give a presentation. She states that the other kids would pick on her and as a result she became withdrawn and depressed, even contemplating suicide. Her parents referred her to counseling at age 15, which helped a little, but didn’t make much difference in terms of overcoming her shyness or improving her social situation at school. At age 16 she began to skip school to avoid the anxiety associate with interacting with other kids, and eventually she dropped out of school. However staying at home all the time did not help her mood, especially since her mother began nagging her to go get a job. At that point in time she developed a deepening depression, and so she went to see Dr. McDonald and was started on sertraline 100mg qd. This helped her considerably. She eventually got her G.E.D., and got a job doing some clerical work for a local insurance agency. She remained there until 2 years ago, when she decided to return to return to school full time at the advice of her father who encouraged her to pursue accounting so she could join him in his firm. She rarely dated until three years ago when she met her boyfriend, a client at the insurance agency where she worked. He is also the first (and only) man with whom she had been sexual active. The relationship ended 9 months ago after he decided he was not ready to get married and wanted to “see other people.” Since then she has been uninterested in dating anyone else. She reports that she feels “unattractive” and has trouble believing that anyone would be interested in her. She states that she wants to have another relationship, but she doesn’t believe that is really possible, and she can’t see making herself vulnerable again.

Currently she lives at home with her parents and her youngest brother (age 22). In the past she enjoyed reading, surfing the internet, and spending time gardening and taking care of her pets (2 cats and 1 dog). Now she is uninterested in hobbies. She has one friend at school that she sometimes goes out with, but she hasn’t been seeing her lately. She reports her family is supportive. She denies use of alcohol, illicit drugs, or tobacco products.

**Mental Status Examination:**

Patient is a slender white female, appearing younger than her stated age, dressed in a plain white t-shirt and jeans, hair pulled neatly back into a ponytail, face pale with no make-up, cooperative but tearful during the interview with only occasional eye contact. Speech is low and soft, she is articulate but at times difficult to understand because the volume is so low. There are no neologisms, blocking, or latency of response. Affect is blunted, mood is depressed. She denies suicidal ideation but admits that sometimes she wishes that she would just “not wake up.” Denies homicidal ideation. Thought processes are clear and goal directed. She denies hallucinations, delusions, thought insertion, thought withdrawal, thought broadcasting, or ideas of reference. Cognition: She is alert and oriented X3, she is able to do serial 7’s quickly and accurately. Immediate, short term and long term memory are all intact as is evidenced by her ability to remember 3 or 3 objects after 5 minutes and her ability to give a good history. Fund of knowledge:

She is able to name the president and last 4 presidents. Vocabulary is consistent with level of education (some college). Calculations: was able to accurately calculate 5 X5=25, 5 X 9=45, 5 X 13 = 65, and 5 x 65 = 115, Abstractions: was able to interpret proverbs and similarities in an abstract fashion. Constructional ability: Was able to copy a three dimensional figure accurately. Insight is good as is evidenced by her recognition that she is suffering from depression. Judgment is intact.

**Review of Systems**:

Gen: Positive for 15lb weight loss over 9 months. Denies weakness, fatigue, fever, chills, night sweats, heat intolerance.
Skin: Denies changes, pruritis, rash, or changes in hair.
Head: Positive for occ migraine headaches.
ENT: Denies visual changes, eye pain, hearing loss, tinnitus, vertigo, ear pain, ear discharge, epistaxis, nasal discharge, sinusitis, teeth problems, abnormal taste, sore throat, or speech difficulty
Neck: Denies neck swelling, pain, stiff neck, goiter, or masses, nodes.
Cardiopulmonary: Denies cough, dyspnea, wheezing, hemoptysis, chestpain, palpitations, orthopnea, P.N.D., murmurs, edema, claudication, syncope, hypertension
GI: Positive for decreased appetite. Neg for n/v, hematemesis, melena, dysphagia, heartburn, flatulence, abdominal pain, jaundice, change in bowel habits, diarrhea, constipation, hematochezia, or rectal pain.
GU: Age menarche: 12. regular menses. G0,P0. Currently on no contraceptives. Has used condoms in the past. Denies dysmenorrhea, menorrhagia, metrorrhagia, dyspareunia, pelvic pain, sexual dysfunction (although currently has no sexual partner), discharge, STD, breast masses, pain, or tenderness, No dysuria, frequency, nocturia, hematuria, urgency incontinence or polyuria.
MS: Denies backache, joint pain, stiffness,
Heme: Denies lympadenopathy, bleeding, bruising, anemia.
Neuro: Denies seizures, paralysis, muscle weakness, parasthesia, sensation changes. Reports occasional tremors (when anxious), and problems with headache.
Psych: Note HPI.

**Physical Exam**:
Vital Signs:
Height: 63 inches
Weight: 115lbs
Temp: 37 C.
RR: 16
BP: 110/62
Pulse: 82 BPM

Appearance: Slender white female, slightly pale, appearing younger than stated age in moderate distress, neatly dressed and groomed.

Skin: soft dry skin, no lesions. Nailbeds pink with no cyanosis or clubbing.
Hair fine, scalp without lesions

Eyes: Visual acuity 20/20 without corrective lenses. Pupils equal, round and reactive to light, Extra ocular movements intact. Conjunctiva pink with no redness or exudates. Eyelids without lesions. Sclera without icterus. Fundi- discs sharp. Vessels without hemmorrages or exudates .

ENT: Hearing grossly intact. External auditory canals patent, free of cerumen, auricles without lesions, tympanic membranes intact with visable landmarks. . Nares patent and-mucus membranes moist without erythema or exudates. No sinus pain to palpation. Mouth: Dentition without lesions. Lips dry and chapped. Gums, tongue and mucosa without lesions. Tonsils slightly enlarged but not erythematous and without exudates. Pharynx clear.

Neck: Full range of motion. Thyroid not palpable. Trachea at midline. No lymphadenopathy.

Breasts: Exam deferred.

Pulm: Chest symmetrical expansion. No deformaties on posterior chest wall. Lungs clear to auscultation and percussion, without adventitious sounds.

CV: No JVD. No deformaties on anterior chest wall. PMI at 5th intercostals space, midclavicular line. Heart sounds-RRR, Normal S1 and single S2. No S3, S4, rubs, or murmurs. Carotids 2+ bilaterally without bruits. .

Abd: No scars, inspection unremarkable. Bowel sounds normoactive No pain to superficial or deep palpation. Liver span 7 cm at the midclavicular line. Spleen not palpated. GU exam not performed

Musculoskeletal: Full range of motion. no pain, edema, or deformity.
Pulses full and equal. No cyanosis, clubbing, or edema.

Neuro: Cranial nerves II-VII intact, Muscle bulk is appropriate in upper and lower extremities. Motor strength is 5/5 in upper and lower extremities bilaterally. Sensation intact to light touch, temperature, and pinprick. DTRs 2+ in biceps, triceps, quadriceps and ankles. Gait full without impairment. Coordination-able to do rapid alternating movements well and finger to nose test well with eyes open and closed. Babinski responses downgoing bilaterally. Romberg negative.

**Assessment:**

Patient is a 24 year old SWF with a long history of social anxiety disorder which appears to have impacted her life in a significant way, leading to a curtailment in her development educationally, socially and occupationally. This led eventually to depression which was successfully treated with sertraline for some time, until she was overcome by the grief of losing a significant relationship in her life, that of her first real boyfriend. The degree of her social anxiety is so profound is possible she may even meet criteria for avoidant personality disorder. Currently her most significant problem is a major depressive episode of 9 months duration, which is not responding to a change of medications. To date she has only had one decent trial of an alternate medication (escitalopram) in terms of length, but since the medication was not increased to its

maximum dosage (20mg) we cannot be sure that it would not have been effective at a higher dosage. The trial of paroxetine was not a good trial because of ineffective length (1 week) and she has not been on the venlafaxine long enough to see if it will be effective.

Diagnosis:

Axis I: Major Depressive Disorder, Recurrent, Severe
Social Anxiety Disorder
Rule out generalized anxiety disorder
Axis II: R/O Avoidant Personality Disorder
Axis III: Migraine Headaches
Axis IV: Mild: Having difficulty going to school and considering dropping out
Axis V: GAF=55

Treatment Plan: Since the patient is not acutely suicidal at present, and she is not psychotic, she does not currently meet criteria for hospitalization. Therefore will attempt to treat her as an outpatient.

1.Will recommend that she increase her Venlafaxine to 150mg qd for 7 days, then go up again to 225mg qd for 7 day, and then to 300mg qd. For the noradrenergic reuptake properties of venlafaxine to take effect, the dosage must be increased to at least 225mg per day, and preferably 300mg per day. The patient should be warned about the potential side effects of going up including nausea, insomnia, and increased blood pressure.

2. For sleep problems, will prescribe rozerem 8mg po qd. This medication has the advantage that it is a melatonin receptor agonist, and has no addictive potential.

3. Will refer to a psychotherapist for cognitive behavioral therapy to help augment the somatic therapies, to assist with her grieving over her ended relationship, and to assist her with anxiety so that she might be better able to cope and achieve the attainment of future goals,

4. Will recommend that she follow up with her psychiatrist within a week to discuss these plans, but that if she feels worse, or becomes suicidal, that she should return to the E.D. to reevaluate her situation or be considered for hospitalization.