Andres Hernandez

H&P #2 – Psychiatry

Identifying Data:
Full Name: M.D.S.G
Address: Queens, NY
Date of Birth: 4/28/1983
Age: 41
Date: 5/3/2024, 11:00 am
Location: Queens Hospital Center Psychiatric Emergency Room
Religion: Unspecified
Marital Status: Single
Source of Information: Self
Reliability: Reliable
Source of Referral: Self
Mode of Transport: EMS

CC: “Suicidal Ideation” x 1 day.

HPI:
A 41-year-old Hispanic female, widowed, domiciled with her sons (aged 8, 22, 24 yo) and currently unemployed, with no past medical or psychiatric history, presents to the Comprehensive Psychiatric Emergency Program, brought in by EMS following alleged suicidal ideation one day ago. The patient explains that yesterday while she was at home cooking for her three children, her 24-year-old son refused to eat. This incident caused her to feel agitated and cry. To avoid an argument with her son, she decided to leave the house with her youngest son and mentioned that she would "disappear." She clarifies that by saying she would "disappear," she meant she wanted to go for a walk to clear her mind and had no intention of hurting herself or anyone else.

During evaluation, the patient appears sad and anxious but remains calm, cooperative, and maintains good eye contact. Since arriving in the United States from Ecuador in February 2024, pt. explains that she has been experiencing significant stress, leading to feelings of depression. She has been struggling with the challenges of adjusting to a new life. She is also burdened by financial debts in her home country, is currently unemployed, and feels guilty that her eldest son is shouldering the family's financial responsibilities. Pt. admits to the loss of her husband nine years ago in a motorcycle accident in Ecuador. She expresses her desire to work and provide for her youngest son but acknowledges that it has been challenging.

Collateral information provided by the eldest son reveals that he contacted the New York Police Department concerned for his mother and younger brother's safety, as she had mentioned going to the train station and jumping in front of a train. The patient's youngest son is safe with her daughter. The patient denied going to the train station, explaining that she took a walk to calm down after leaving home. She received a call from her neighbor while waiting for the bus, informing her that the police were at her apartment. She cooperated with the police officer over the phone and met with them. Police decided that she should visit the hospital for evaluation.

The patient acknowledges that she feels better now but admits that she is still dealing with life's challenges, which sadden her. However, she denies feeling hopeless and remains optimistic that her situation will improve. She admits to having a positive relationship with her children and understands why her son was concerned for their safety. She denies any suicidal thoughts or intentions, as well as any desire to harm others. The patient has no medical complaints at this time. She also denies experiencing any visual or auditory hallucinations and reports no alcohol or drug use.

Past Psychiatric History:
-Anxiety, unknown onset, not medically managed.
-Depression, unknown onset, not medically managed.

Past Medical History:
-No past medical history.
-Denies childhood illnesses.
-Immunizations up to date.

Past Surgical History:
-No past surgical history.
-Denies blood transfusions and past injuries.

Medications:
-No medication use.

Allergies:
-None

Family History:
Mother- alive and healthy.
Father – alive and healthy.
No pertinent family history.

Social History:
Patient with children.
Habits- denies alcohol, caffeine use, drug use.
Relationship status – single.
Sleep – unknown was not asked.
Appetite - unknown was not asked.
Exercise- does not exercise.
Past arrest/incarceration history – none

ROS:
General – Denies insomnia, recent weight loss, generalized weakness/fatigue, fever or chills, or night sweats.

Eyes – Denies photophobia, visual disturbances, lacrimation, pruritus, or use of contact lenses.

Ears – Denies deafness, pain, discharge, tinnitus, or use of hearing aids.

Pulmonary System - Denies shortness of breath or cough.

Cardiovascular System - Denies chest pain, HTN, palpitations.

Gastrointestinal system – Denies abdominal pain, and nausea.

Genitourinary system – Denies urinary frequency or urgency, nocturia, oliguria, polyuria, dysuria, incontinence, awakening at night to urinate or flank pain.

Nervous – Denies seizures, headache, dizziness, speech change, or weakness.

Endocrine system – Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism, or goiter.

Psychiatric –Has no history of depression, anxiety. Denies suicidal ideation attempt, homicidal thoughts, hallucinations, seeing a therapist.

Physical exam:
General: female, appears her stated age, height, and weight, awake, groomed, alert and oriented x 3, in no acute distress, responds quickly to questions, has good color. Can ambulate without assistance.

Vital signs:
BP: 114 mm Hg (BP location: Right arm)
R: 18 breaths/min, unlabored
P: 80 beats/min, regular
T: 98.0 degrees F (oral)
O2 Sat: 97% room air
Height: 1.524 m (5’0”) Weight: 54.4311 kg (144 lb) BMI: 28.1 kg/m2

Mental Status Exam:
General
1. Appearance: alert, appears of stated age, casually groomed, well-nourished, good eye contact.
2. Behavior and Psychomotor Activity: Patient is guarded and anxious at times but cooperative.
3. Attitude Towards Examiner: Patient is cooperative during the interview.

Sensorium and Cognition
1. Alertness and Consciousness: The patient was conscious and alert throughout the interview.
2. Orientation: Patent was oriented to the date, place, and time of the interview.
3. Concentration and Attention: Good concentration and unimpaired memory.
4. Capacity to read and write: Patient can read and write.
5. Abstract thinking: Proper ability to abstract think.
6. Memory: Memory was unimpaired.

7. Fund of information and knowledge: patient's intellectual performance consistent with level of education.

Mood and Affect
1. Mood: Anxious, Sad/Depressed
2. Affect: Constricted
3. Appropriateness: Mood and Affect were congruent throughout the interview

Motor
1. Speech: Patient's speech was normal
2. Eye Contact: Patient made good eye contact
3. Body Movements: No psychomotor abnormalities

Reasoning and Control
1. Impulse Control: Poor impulse control. Patient denies any suicidal ideations and plans.
2. Judgement: Patient had impaired judgement based on appreciating consequences of actions.
3. Insight: Patient has poor insight into psychiatric condition and could be minimizing behavior.

Assessment:
A 41-year-old Hispanic female, with no past psychiatric history, is brought to the psychiatric emergency room by ambulance due to alleged suicidal ideations. On assessment, the patient appears sad, tearful with constricted affect and depressed mood. The patient currently exhibits impaired insight, poor judgement, and impulse control. Currently, although the patient denies suicidal gesture/attempt, patient could be minimizing her behavior especially with inconsistent details that differs from collateral information. With the current presentation of depressive symptoms and multiple psychosocial stressors, a patient can be risk to herself and others and warrants observation and stabilization. Re-evaluate in the morning.

Differential Diagnosis:
1.Adjustment disorder with depressed mood – presents with dysphoria that occurs on the context of psychosocial stressors. Adjustment disorder is diagnosed if symptoms do not meet the criteria for another specific disorder. Depressed mood that occurs in response to a psychosocial stressor or multiple stressors. Diagnostic criteria, low mood, tearfulness, or feelings of hopelessness in response to stressor within three months.

2.Major depressive disorder (unipolar major depression) - diagnosed in patients with a history of major depressive episode lasting at least two weeks, and no history of mania or hypomania. At least one of the symptoms must be depressed mood or anhedonia. The depressive episode is not caused by medications or general medical conditions.

3.Persistent depressive disorder (dysthymia) – chronic depressed mood; like major depressive disorder but with the difference is that it lasts at least two years. It has two or more of the following: appetite disturbances, sleep disturbances, low energy, low self-esteem, poor concentration, hopelessness.

4.Prolonged grief disorder – form of grief that is unusually intense and disabling. Maladaptive thoughts, dysfunctional behaviors, dysregulated emotions that impede adaptation to loss.

Prolonged grief disorder has unrelenting grief symptoms that persists beyond the time expected by one's social and cultural context, thought to be at least 6 to 12 months after the death of a loved one. Differs from major depression in that grief disorder is preoccupation with the decreased whereas in depression the core symptoms are sadness and loss of interest and pleasure.

5.Normal Stress Response- Not excessive or out of proportion response to severity of stressor. No significant functional impairment. Sadness and irritability (dysphoria) is generally a normal, adaptive part of the human condition, particularly in response to loss, disappointment, or perceived failure.

Plan:
-Observe patient overnight for unpredictable behavior.
-Start on medication (mirtazapine) Remeron 7.5 mg at bedtime.
-Discuss safety plan with patient.
-Re-evaluate in the morning for any change in behavior. Check for suicidal ideation, intent, or plan. Assess any changes in mood, impulse control, judgement, and insight.
-Determine on the morning if the patient requires continual CPEP or inpatient admission or can be discharged.
-If discharged refer to follow-up with adult outpatient psychiatry department.