Anonymized Medical Record

Patient Demographics

Patient ID:

FH-006

Date of Birth:

1990-05-18 (Age: 35)

Gender:

Female

Ethnicity:

South Asian

Chief Complaint (CC)

:

Worsening low mood and anxiety.

History of Present Illness (HPI)

:

35-year-old female presents with worsening low mood, anhedonia, and anxiety symptoms over the past 3 months. Reports feeling persistently sad, losing interest in hobbies she once enjoyed (reading, hiking), and experiencing difficulty sleeping (insomnia, early morning awakening). Increased irritability and fatigue. Anxiety manifests as constant worry, restlessness, and occasional panic attacks (last one 2 weeks ago). States stress at work and recent relationship difficulties are contributing factors. Diagnosed with Major Depressive Disorder and Generalized Anxiety Disorder 2 years ago, previously well-controlled on medication.

Past Medical History (PMH)

:

- Major Depressive Disorder
- Generalized Anxiety Disorder
- Migraines (infrequent)

Medications

:

- Sertraline 50mg daily (patient reports taking inconsistently recently)
- Alprazolam 0.25mg PRN for anxiety (uses 2-3 times/week)

Allergies

:

None known.

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Family History (FH)

:

- Mother: History of depression.
- Father: History of anxiety.

Social History (SH)

:

Works in marketing. Single. Lives alone. Occasional social alcohol use, denies illicit drug use. Feels isolated since relationship difficulties.

Review of Systems (ROS)

:

- Psychiatric: Low mood, anhedonia, irritability, fatigue, poor concentration, feelings of worthlessness. Anxiety, restlessness, panic attacks, constant worry. Suicidal ideation denied.
- Constitutional: Denies fever, chills, significant weight change (reports slight weight loss due to decreased appetite).
- Neurological: Denies numbness, tingling, weakness. Occasional mild tension headaches, distinct from migraines.
- Sleep: Insomnia, difficulty falling asleep, early morning awakening.

Physical Examination (PE)

:

- Vitals: Temp 98.0°F, HR 78, RR 16, BP 120/80.
- General: Appears tired, but well-groomed. Maintains eye contact. Speech coherent, normal rate.
- Affect: Constricted, congruent with dysphoric mood.
- Mood: Reports 'sad, anxious.'
- Thought Process: Linear, logical.
- Thought Content: Preoccupied with work and relationship issues. No delusions or hallucinations.
- Cognition: Alert and oriented x 3, concentration fair.
- Insight: Good.
- Judgment: Good.

Assessment

:

1. Major Depressive Disorder, recurrent, moderate episode.
2. Generalized Anxiety Disorder, exacerbated.
3. Medication non-adherence.

Plan

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:

1. Medications: Increase Sertraline to 75mg daily. Emphasize importance of consistent daily dosing. Review Alprazolam use, discuss risks of long-term benzodiazepine use. Explore non-pharmacological anxiety management.
2. Therapy: Strong recommendation for individual psychotherapy (CBT preferred) to address coping mechanisms, stress management, and relationship issues. Provide referrals.
3. Lifestyle: Encourage consistent sleep hygiene, regular exercise, and healthy diet. Advise on limiting alcohol and caffeine.
4. Safety: Assess for suicidal ideation, contract for safety (patient denies SI and agrees to reach out if thoughts arise).
5. Follow-up: Return in 2 weeks to assess medication response and adherence, and discuss therapy engagement.