Patient Name: John D.

Age: 42

Gender: Male

Date: 2025-08-31

Physician: Dr. Smith

Chief Complaint:

Patient reports persistent feelings of sadness, lack of motivation, and difficulty sleeping for the past 3 months.

He describes increased irritability at work and frequent arguments with family.

History of Present Illness (HPI):

- Reports low energy and loss of interest in previously enjoyable activities.

- Appetite reduced, with ~5kg unintentional weight loss.

- Occasional headaches, denies chest pain or shortness of breath.

- Endorses episodes of anxiety with palpitations and sweating.

- Patient admits to thoughts of hopelessness but denies current suicidal plan or intent.

Past Medical History:

- Hypertension (controlled with medication)

- No history of psychiatric hospitalization

Medications:

- Lisinopril 10mg daily

- Occasional use of over-the-counter sleep aid

Social History:

- Works as an IT consultant, married with 2 children

- No tobacco, drinks alcohol socially (2–3 drinks per week)

- No recreational drug use

Mental Status Exam:

- Appearance: Well-groomed, cooperative

- Mood: Depressed

- Affect: Restricted

- Thought Process: Linear, logical

- Thought Content: Reports negative self-worth, denies hallucinations or delusions

- Insight/Judgment: Fair

Assessment:

Major Depressive Disorder, moderate severity

Generalized Anxiety Disorder

Plan:

- Start SSRI (Sertraline 25mg daily, titrate as needed)
- Referral to psychotherapy (CBT recommended)
- Encourage regular exercise and sleep hygiene
- Follow-up in 4 weeks
- Provide crisis hotline information in case suicidal ideation worsens