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