**H&P 4 for PSYCH**

**Identifying Data:**

Full Name: T.C.

Date of Birth: xx/xx/1990

Age: 28 y/o

Sex: Male

Date & Time: 06/13/2019, 10:30 am

Location: QHC, Jamaica, NY

Religion: N/A

Source of Information: Self, brother (L.C.) and mother (L.H., 347-xxx-xxxx)

Reliability: reliable

Source of Referral: Mother (L.H., 347-xxx-xxxx)

**Chief Complaint:** paranoid and poor functioning for 5 years, worsening for 2 months.

**History of Present Illness:**

28 y/o male with no past psych treatment, domiciled with mother, father and brother, single, self-employed, sent by brother (L.C.) activated by mother (L.H., 347-xxx-xxxx) for psychiatric evaluation secondary to paranoid and poor functioning. Patient reports that he always feels someone wants to hurt him or tries to steal his ideas on computer for 5 years. Sometimes, he was depressed, anxious, and felt hot or cold sometimes. Symptoms worsen for 2 months. He has insomnia, loss of appetite, difficulty in remembering things, and cannot concentrate on work. Brother and mother confirmed the information. Mother reported that recently patient told her that he wanted to hurt himself and he became quiet for 2 months. Upon evaluation, patient is casually groomed, cooperative, anxious and depressed. Patient denied substance use disorder, AH/VH, homicidal ideation or current suicidal ideation.

**Past Medical History:** None

**Past Surgery History:** None

**Past Hospitalization History:** None

**Immunizations** – Up to date

**Medications:** None

**Allergies:** Denies any drug, environmental or food allergies.

**Family History:** non-contributory.

**Social History:** Single, self-employed, living with mother, father and brother. Denied smoking, alcohol drinking, or illegal drug use. Denies recent travelling. Regular diet. Sexually active, only with girlfriend. Denied STD.

**Review of Systems:**

General –Denies recent weight loss or gain, loss of appetite, generalized weakness/fatigue, fever, chill or night sweats.

Skin, hair, nails – Denies excessive sweating, moles or changes in hair distribution.

Head – Denies headaches or head trauma.

Eyes – Denies pain, redness, swelling, visual disturbances, or photophobia. No glasses.

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

Nose/sinuses – Denies discharge, obstruction or epistaxis.

Mouth/throat – Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes or use dentures. No recent dental exam.

Neck – Denies localized swelling/lumps or stiffness/decreased range of motion.

Pulmonary system – Denies dyspnea, dyspnea on exertion, cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

Cardiovascular system –Denies chest pain, palpitation, irregular heartbeat, edema/swelling of ankles or feet, syncope or known heart murmur.

Gastrointestinal system –Denies change in appetite, intolerance to specific foods, dysphagia, abdominal pain, nausea, vomiting, constipation, diarrhea, or jaundice. Last colonoscopy, 2016, normal.

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

Nervous –Denies seizures, headache, loss of consciousness, ataxia, loss of strength, change in cognition / mental status / memory, or weakness.

Musculoskeletal system – Denies muscle/joint pain, deformity or swelling, redness or arthritis.

Peripheral vascular system – Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema or color changes.

Hematological system – Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions, or history of DVT/PE.

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

Psychiatric – See hpi.

**Physical Exam:**

General: Male, well developed, anxious, depressed. Alert and cooperative. AAA x3. Looks just like his age.

Vital signs: BP: R L

 Seated 108/72 112/72

 R: 18 breaths/min, unlabored

 P: 78 beats/min, regular

 T: 36.6 degrees C (oral)

 O2 Sat: 94% Room air

 Height 69 inches Weight 134 lbs. BMI: 19.8

Skin: warm, good turgor. Nonicteric, no tattoos. Dry, raised, red skin lesions covered with silvery scales on left lower leg.

Hair: black color, average quantity and distribution.

Nails: no clubbing, capillary refill <2 seconds throughout.

Head: normocephalic, atraumatic, non tender to palpation throughout

Eyes: symmetrical OU; no evidence of strabismus, exophthalmos or ptosis; sclera white; conjunctiva & cornea clear. Visual acuity-deferred. Visual fields full OU. PERRLA. EOMs full with no nystagmus. Fundoscopy - deferred.

Ears: Symmetrical and normal size. No evidence of lesions/masses / trauma on external ears. No discharge / foreign bodies in external auditory canals AU. TM's pearly white / intact with light reflex in normal position AU. Auditory acuity intact to whispered voice AU. Weber midline / Rinne reveals AC>BC AU.

Nose: Symmetrical / no obvious masses / lesions / deformities / trauma / discharge. Nares patent bilaterally / Nasal mucosa pink & well hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesions / deformities / injection / perforation. No evidence of foreign bodies.

Lips: Pink, moist; no evidence of cyanosis or lesions. Non-tender to palpation.

Mucosa: Pink ; well hydrated. No masses; lesions noted. Non-tender to palpation. No evidence of leukoplakia.

Palate: Pink; well hydrated. Palate intact with no lesions; masses; scars. Non-tender to palpation.

Teeth: Good dentition / no obvious dental caries noted.

Gingivae: Pink; moist. No evidence of hyperplasia; masses; lesions; erythema or discharge. Non-tender to palpation.

Tongue: Pink; well papillated; no masses, lesions or deviation noted. Non-tender to palpation.

Oropharynx: Well hydrated; no evidence of injection; exudate; masses; lesions; foreign bodies. Tonsils present with no evidence of injection or exudate. Uvula pink, no edema, lesions

Neck: Trachea midline. No masses; lesions; scars; pulsations noted. Supple; non-tender to palpation. FROM; no stridor noted. 2+ Carotid pulses, no thrills; bruits noted bilaterally, no palpable adenopathy noted.

Thyroid: Non-tender; no palpable masses; no thyromegaly; no bruits noted.

Chest: Symmetrical, no deformities, no evidence trauma. Respirations unlabored / no paradoxic respirations or use of accessory muscles noted. Lat to AP diameter 2:1. Non-tender to palpation.

Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus intact throughout. No adventitious sounds.

Heart: JVP is 2.5 cm above the sternal angle with the head of the bed at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm (RRR); S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs or other extra sounds.

Abdomen: Flat/ symmetrical / no evidence of scars, striae, caput medusae or abnormal pulsations. BS present. No bruits noted over aortic/renal/iliac/femoral arteries. Tympany to percussion throughout. Soft. No evidence of organomegaly. No masses noted. No evidence of tenderness, guarding or rebound tenderness. No CVAT noted bilaterally.

Rectal: deferred.

Peripheral Vascular: Bilateral lower leg edema, non-pitting ++. Skin normal in color and warm to touch upper and lower extremities bilaterally. No calf tenderness bilaterally, equal in circumference. Homan's sign not present bilaterally. No palpable cords or varicose veins bilaterally. No palpable inguinal or epitrochlear adenopathy. No cyanosis, clubbing / noted bilaterally.

Neurological:

Mental Status: Alert and oriented to person, place and time. Attention intact. Anxious, depressed and co-operative. Unremarkable speech and good eye contact. Mild insight, impaired impulse control and judgement. (appearance: casually groomed; behavior: WNL; attention: alert; attitude: co-operative; speech: unremarkable; mood: anxious, sad, depressed; affect: constricted; though pattern/process: no disorder; thought content: paranoid ideas (non-delusional); perception: unimpaired; delusion: persecutory; hallucinations: none; suicidal ideation: passive; homicidal ideation: none; concentration: impaired; abstract: fair; insight: mild; judgement: impaired; impulse control: impaired)

Cranial Nerves

II- Visual fields by confrontation full. Fundoscopy deferred.

III-IV-VI- PERRLA, EOM intact without nystagmus.

V- Decreased sensation of the right side of face, strength good. Corneal reflex intact bilaterally.

VII- Facial movements symmetrical and without weakness.

VIII- Hearing grossly intact to whispered voice bilaterally. Weber midline. Rinne AC>BC.

IX-X-XII- Swallowing and gag reflex intact. Uvula elevates midline. Tongue movement intact.

XI- Shoulder shrug intact. Sternocleidomastoid and trapezius muscles strong.

Motor/Cerebellar: Full active/passive ROM of all extremities without rigidity or spasticity. Normal muscle bulk and tone. No atrophy, tics, tremors or fasciculations. Strength equal and appropriate for age bilaterally (5/5 throughout). No Pronator Drift. Gait normal with no ataxia. Coordination by RAM and point to point intact bilaterally. Romberg negative.

Sensory: Decreased sensation of the right arm to light touch. Intact to sharp/dull, vibratory, proprioception, point localization, extinction, stereognosis and graphesthesia testing bilaterally.

Reflexes R L R L

Brachioradialis 2+ 2+ Patellar 2+ 2+

Triceps 2+ 2+ Achilles 2+ 2+

Biceps 2+ 2+ Babinski neg neg

Abdominal 2+/2+ 2+/2+ Clonus negative

Meningeal Signs: No nuchal rigidity noted. Brudzinski's and Kernig's signs negative.

Musculoskeletal: No soft tissue erythema / edema / ecchymosis / atrophy / or deformities in bilateral upper and lower extremities. Non-tender to palpation / no crepitus noted throughout. FROM (Full Range of Motion) of all upper and lower extremities bilaterally. No evidence of spinal deformities.

**Assessment:** 28 y/o male with no past psych treatment, domiciled with mother, father and brother, single, self-employed, sent by brother activated by mother for psychiatric evaluation due to paranoid and poor functioning, compatible with Schizoaffective disorder.

**Plan:**

1. Admit to CPEP for observation and stabilization.
2. Lab (CBC, BMP, TSH, and drug screen).
3. Head CT.
4. Start medications: lorazepam 2 mg im once, 2 mg PO qdaily; haloperidol 5 mg im once, 5 mg qdaily; risperidone 1 mg PO bid; trazodone 50 mg qdaily at night)
5. Re-evaluation in AM.

Differential diagnosis based on the chief complaint: Psychiatric: Schizoaffective disorder, Depression with psychotic features, Psychotic disorder (brief), Bipolar disorder, Schizophrenia; Medical: Autoimmune disorders (e.g., multiple sclerosis, systemic lupus erythematosus), Endocrine disorders (e.g., Cushing disease, diabetes mellitus, thyroid disease), Neurologic conditions (e.g., dementia, encephalitis, epilepsy, Parkinson disease), Nutritional conditions (e.g., vitamin B deficiency), Oncologic conditions (e.g., ovarian teratoma, small cell lung cancer), Medication (marijuana, alcohol, cocaine, meth, LSD, and bath salts). I list all these possible disorders because all of them could lead to paranoid.

Differential diagnosis after H&P, lab tests and CT: Schizoaffective disorder

Firstly, after H&P and tests, all of medical problems could be ruled out without any supporting history, symptoms and/or signs, or tests. Except the psychiatric symptoms and mental status, others are all unremarkable.

Secondly, after H&P, significant depression (mood disordered symptom) does not support schizophrenia, no manic symptoms to support bipolar disorder, long term symptoms do not support psychotic disorder, paranoid is more significant than depression (per patient, he had paranoid without depression at least several months), not supporting depression with psychotic features.

Work up: CT and lab tests negative. After management, the patient relaxed and calmed, not a threat to self or others and was discharged to our patient program and will follow up with psychiatrist within 2 weeks.

Patient education:

Schizoaffective disorder (SZA, SZD or SAD) is a mental disorder characterized by abnormal thought processes and an unstable mood. The diagnosis is made when the person has symptoms of both schizophrenia (usually psychosis) and a mood disorder—either bipolar disorder or depression—but does not meet the diagnostic criteria for schizophrenia or a mood disorder individually. The main criterion for the schizoaffective disorder diagnosis is the presence of psychotic symptoms for at least two weeks without any mood symptoms present.

There are two types of schizoaffective disorder: the bipolar type, which is distinguished by symptoms of mania, hypomania, or mixed episode; and the depressive type, which is distinguished by symptoms of depression only. Common symptoms of the disorder include hallucinations, delusions, and disorganized speech and thinking.[8] Auditory hallucinations, or "hearing voices," are most common. The onset of symptoms usually begins in young adulthood.

Genetics, neurobiology, early and current environment, behavioral, social, and experiential components appear to be important contributory factors. No single isolated organic cause has been found, but extensive evidence exists for abnormalities in the metabolism of tetrahydrobiopterin (BH4), dopamine, and glutamic acid in people with schizophrenia, psychotic mood disorders, and schizoaffective disorder. People with schizoaffective disorder are likely to have co-occurring conditions, including anxiety disorders and substance use disorders. The average life expectancy of people with the disorder is shorter than those without it.

The mainstay of current treatment is antipsychotic medication combined with mood stabilizer medication or antidepressant medication, or both. When there is risk to self or others, usually early in treatment, hospitalization may be necessary. Psychiatric rehabilitation, psychotherapy, and vocational rehabilitation are very important for recovery of higher psychosocial function.

If your symptoms (depression, paranoia, and delusion) worsen, or have hallucination, or intent to hurt self or others, please go to ER or call your doctor.