RT2-Family medicine H&P1

Jinjin Lin

Identification:

Patient's name: Ms. G

DOB: 22 years old

Gender: female

Race: Hispanic

Location: Amazing medical service, Jamaica NY

Date and Time: 2/20/2019, 5pm

Informant: self, reliable; patient's mother, reliable

CC: "I do not feel well"

HPI: A 22 years old Hispanic female with no significant past medical history come in today complaint of feeling sad for about 3 weeks. Patient reports after getting injection of Depo-Provera on January 28, she feels down, depressed and she has been crying almost every day. She admits fatigue, nausea, abdominal cramps, hot flashes, low energy levels, not interested in usually activities, and difficulty falling asleep or staying asleep. She reports that was the first time she got injection of Depo-Provera, and she denies past psychiatric history. Patient also denies weakness, vomiting, diarrhea, jaundice, change in bowel habits, hemorrhoids, constipation, rectal bleeding, heat or cold intolerance, under stress, any hallucinations or suicidal ideations. Patient's mother is interviewed separately, and reports that her daughter does not have any psychiatric history, and she has been active, stable without depression, and coping with school before taking the birth control injection.

Differential Diagnosis:

- Adverse effect of drug: patient has symptoms of nausea, abdominal discomfort, hot flashes, fatigue, depression, which are all common side effects of Depo-Provera injection, and patient also reports having these symptoms after injection
- Major depression disorder: duration of symptoms > 2 weeks, and symptoms of fatigue, low energy level, difficulties with sleep, not interested in usually activities, feeling down and depressed all support depression disorder

PMH:

Patient denies any past medical history.

Past Surgical History:

Patient denies any past surgical history.

Medications:

Depo-Provera, 150mg, IM, every 3 months, last injection on January 28, 2019.

Allergies:

Patient denies any drug, foods, or environment allergies.

Family History:

Grandfather- 76, alive, HTN, EtOH

Grandmother- 71, deceased

Father- 45, alive, HTN

Mother-42, alive, type 1 diabetes

Social History:

Ms. G lives with her parents in Queens NY. Currently, she is a college student and she has a part time job in Burger king. Not sleep well, hard to fall sleep and always wakes up at night. Usually walks 40 min every day, and she tries to balance her diet. The patient denies recent travel, nicotine use, alcohol consumptions, past or present illicit drug use.

ROS:

General: Patient reports fatigue, and patient denies recent weight loss or weight gain, loss of appetite, generalized weakness, fever, chill or night sweats

Skin, Hair, Nails: Patient denies any changes of texture, excessive dryness or sweating, discolorations, pigmentations, moles, rashes, pruritus, or changes in hair condition

Head: Patient denies headache, vertigo, head trauma, or fracture

Eyes: Patient denies visual disturbance, lacrimation, photophobia, pruritus, or last eye exam

Ears: Patient denies deafness, pain, discharge, tinnitus

Nose/Sinuses: Patient denies discharge, epistaxis, or obstruction

Mouth and throat: Patient denies bleeding gums, sore tongue, sore throat, mouth ulcers or last dental exam

Neck: Patient denies localized swelling or lumps, stiffness or decreased range of motion

Breast: Patient denies lumps, nipple discharge, pain.

Pulmonary System: Patient denies SOB, DOE, cough, wheezing, hemoptysis, cyanosis, orthopnea, paroxysmal nocturnal dyspnea

Cardiovascular System: Patient denies chest pain, palpitations, edema, syncope, or known heart murmur

Gastrointestinal System: Patient reports nausea and abdominal cramps, and denies changes in appetite, intolerance to specific foods, vomiting, dysphagia, flatulence, diarrhea, jaundice, change in bowel habits, hemorrhoids, constipation, rectal bleeding, blood in stool or stool guaiac test or colonoscopy

Genitourinary System: Patient denies changes in frequency, nocturia, urgency, oliguria, polyuria, dysuria, change in color of urine, incontinence, awakening at night to urinate, or pain

Sexual history: Patient is sexually active with men only and use contraception, patient denies STD

Menstrual and Obstetrical: Patient last normal period is about 6 weeks ago, the time of menarche is 12 years old, her menstrual cycle is 28 days with medium flow without clots. Patient denies postcoital bleeding, dyspareunia.

Nervous System: Patient denies seizures, headache, loss of consciousness, sensory disturbances, numbness, paresthesia, dysesthesias, ataxia, loss of strength, change in cognition, mental status, memory, or weakness

Musculoskeletal System: Patient denies muscle or joint pain, deformity or swelling, redness, arthritis

Peripheral System: patient denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, or color changes

Hematological System: Patient denies anemia, easy bruising or bleeding, or lymph node enlargement

Endocrine System: Patient denies polyuria, polydipsia, polyphagia, heat or cold intolerance or goiter

Psychiatric: Patient reports depression, sadness and lack of interest in usual activities, denies feeling of helplessness, hopelessness, anxiety, obsessive or compulsive disorder, seen a mental health professional, or use medications

Physical Examination:

General: 22 years old female is well dressed, alert and cooperative. Slender female, neatly groomed, well developed.

Vital Signs:

BP (seated): 122/78

HR: 84BMP, regular

RR: 16, not labored

Temp: 96.8 F oral

O2 sat: 98% room air

Height: 5ft 4in weight: 124lb BMI: 21.3, normal

Skin: Warm & moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos.

Hair: Average quantity and distribution

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

Head: Normocephalic, atraumatic, non-tender to palpation throughout

Eyes: Symmetrical OU; no strabismus, exophthalmos or ptosis; sclera white; conjunctiva & cornea clear. Visual acuity with glasses 20/20 OS, 20/20 OD, 20/20 OU. Visual fields full OU. PERRLA, EOMs full with no nystagmus. Fundoscopy - Red reflex intact OU.

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

Nose: Symmetrical with no masses, lesions, deformities, or trauma. Nasal mucosa pink, no discharge or foreign bodies. Anterior septum deviated to left, no lesions, deformities, injection perforation

Sinuses: Nontender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses

Lips: Pink, dry, no cyanosis or lesions

Mucosa: Light pink, dry, no masses, lesions, or leukoplakia

Palate: Pink, hydrated. Palate intact with no lesions, masses, scars, nontender to palpation, continuity intact

Teeth: Not wearing dentures

Gingivae: Pink, no hyperplasia, masses, lesions, erythema, or discharge

Tongue: Pink, no masses, lesions, or deviations noted

Oropharynx: Hydrated, no injection, exudate, masses, lesions, or foreign body. Tonsil present with no injection or extrudate, uvula light pink, no edema or lesions

Neck: No masses, lesions or scars. Trachea midline, pulsation noted. Supple nontender to palpation. 2+ carotid pulses, no thrills, bruits bilaterally. No palatable adenopathy

Thyroid: Nontender, no palpable masses, no thyromegaly, no bruits

Chest: Symmetrical, lat to AP diameter 2:1, no deformities, no trauma. Respirations unlabored. Nontender to palpation

Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus intact throughout. No wheezing, crackles, rales

Heart: S1, S2 without murmur, no gallops, S3 or S4. RRR. No JVD. Carotid pulse are 2+ bilaterally without bruits

Abdomen: Flat, symmetrical, no scars, striae, or abnormal pulsations. Bowel sounds in all 4 quadrants. No bruits. Tympany to percussion throughout. Nontender to percussion or to light and deep palpation. No organomegaly, guarding, or rebound tenderness. No CVAT bilaterally

Rectal: No external hemorrhoids, ulcers, anal fissures, inflammation or excoriations. Good anal sphincter tone. No masses or tenderness

Female genitalia: External - normal pubic hair pattern, no erythema, inflammation, ulcerations, lesions or discharge

Peripheral vascular: The extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits, clubbing, cyanosis or edema noted bilaterally. No stasis changes or ulcerations noted

Neurological:

Mental status: Alert and oriented to person, place and time. Memory and attention intact. Sad and depressed mood with constrict affect. Good eye contact during interview. Thought process is logical and coherent, fair insight and judgement.

Cranial nerve:

I – not exanimated

II- VA 20/20 bilaterally. Visual fields by confrontation full. Fundoscopic + red light reflex OS/OD

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

V- Facial sensation intact, 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 and 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. Tandem walking and hopping show balance intact. Romberg negative

Sensory: Intact to light touch, sharp/dull, vibratory, proprioception, point localization, extinction, stereognosis and graphesthesia testing bilaterally

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

Musculoskeletal System:

Upper extremities and lower extremities: No soft tissue swelling, erythema, ecchymosis, atrophy or deformities in bilateral upper and lower extremities. Nontender to palpation, no crepitus noted throughout. Full range of motion of all upper and lower extremities bilaterally. No spinal deformities

Differential Diagnosis:

- Adverse effect of drug
- Major depression disorder
- Hypothyroidism: patient has symptoms of fatigue and depression support hypothyroidism, but patient does not have other typical symptoms of constipation, weight gain, muscle pain or goiter. Less likely, will need thyroid profile to rule out.

Assessment: A 22 years old female with no reported past medical history or psychiatric history come in complaint of feeling down for 3 weeks. Patient reports feels down, depressed, fatigue, nausea, abdominal cramps, hot flashes, low energy levels, anhedonia, insomnia after her first injection of Depo-Provera on January 28.

Plan:

- Lab work: thyroid profile, CBC, CMP, HCG
- Discontinue Depo-Provera injection
- Start Zoloft 25mg, PO, QD, 14 days
  Note: patient has good family support, and she refuses counseling for now
- Follow up within 14 days to re-evaluate the depression, refer to therapy or psychiatry if necessary

Patient education:

Your depression symptoms, like feeling tired, down and sad, crying, cannot get into sleep, and loss interest of doing usual activities; and other symptoms of nausea and abdominal cramps are likely due to birth control injection, Depo-Provera, you got on Jan 28. Since you do not want to go counseling at this time, and family are very supportive, I will give you Zoloft to temporarily help you to get over the side effects of Depo-Provera. The medication's name is Zoloft, it is a tablet, 25mg, take it orally, once a day, for 14 days. And I would like you to know that Zoloft has side effects as well, like drowsiness, feeling anxious, loss of appetite, decrease sex drive, and shaking. In addition, we will do some lab tests to rule out thyroid problems and rule out pregnancy. We will call you if the results are ready. This medication is only for temporarily relief of depression, I want you to come back and follow up within 14 days, before you finish the pills, and we will re-evaluate you and see what we can do from there.