THE UNIVERSITY OF CHICAGO HOSPITALS
Department of Psychiatry
5841 South Maryland Avenue- MC 3077
Chicago, Illinois 60637

ADULT PSYCHIATRY OUTPATIENT DEPARTMENT
DIAGNOSTIC EVALUATION

Patient:	XXXXXXXX
Medical History #:	XXX-XX-XX
Date of Birth:	XX/XX/XX
Age:	37
Examining Clinician: (Resident):	Dr. XXXXX XXXXX
Attending Physician:	Dr. XXXX XXXXXXXX
Referral Source:	Dr. XXXXX
Date of Evaluation:	11/9/01

The patient is a 37 year old married Caucasian male, a business executive and the father of one, referred by his UCH gastroenterologist, Dr. XXXXX. His medical chart was unavailable. He is a reliable historian.

CC: "I've always been a worrier…."

HPI: The patient presents to the psychiatry clinic with complaints of anxiety and depression for the past two years. He reports that he has always been a worrier. However, things became increasingly worse two years ago. At that time, he was working for a technology company and was on the "fast track" to becoming the youngest executive. Despite his adequate work performance, he felt overwhelmed. For instance, although he had had a great deal of success with public speaking in giving presentations in graduate school, he found it difficult to give presentations at work and would even have trouble introducing himself in small groups. As a result, he left the company for a job at another company with fewer responsibilities and less pay. After working there several months, his old boss convinced him to return to that firm. Around the same time, he informed his gastroenterologist, Dr. XXXXX, of his increased anxiety. He had been hesitant to mention it before that time because he was embarrassed. Dr. XXXXX placed him on lorazepam and he was titrated to a dose of 2 mg every eight hours. The patient reports that he does not notice much of a difference in his anxiety even when he occasionally doubles the dose.

This past June, while the patient was in the hospital for surgery for Crohn's Disease, his symptoms of anxiety and depression got markedly worse. He describes this period as an "emotional nightmare." He reports that he had difficult sleeping in the hospital and would stay up all night watching the news and then worrying about the stories he saw. He stated that he also worried excessively about his then 11 month old son. For instance, one night while in the hospital he saw a story on the news about a car ac

seeing the story, he could not stop worrying about his son or thinking about how he would feel if anything every happened to his child. When he returned home from the hospital he had many crying spells. Since then, he reports low mood, decreased sleep, decreased interest, and low energy. He reports a good appetite and denies problems with memory or concentration. He has no suicidal or homicidal ideation. He continues to worry about his son. States that his son has just learned to walk and that he gets nervous when his son falls thinking that his son "will break his neck." He also reports that his son has small bruises from his falls on the hard wood floors and that he recently insisted that the pediatrician work up the toddler for a bleeding disorder. Lastly, while at a routine check-up, the pediatrician noticed that the baby has a heart murmur. Now the patient is extremely focused on that and worries that his son needs to see a cardiologist. He reports that even his wife has told him that he needs to "relax and chill out." Despite reassurance from others he cannot stop worrying even though he realizes intellectually that the worries are all but groundless.

Past Psychiatric History: The patient stated that he has been anxious for as long as he can remember. He began taking medication for his anxiety prescribed by his gastroenterologist two years ago. He also describes himself as "very anal." States that he's "particular about how [he does] business." In addition, he keeps extremely detailed files at home with his family's and his own medical records. He has never seen a psychiatrist and has never been in counseling with clergy or a therapist.

PMH: He was diagnosed with Crohn's in 1980. Since that time, he has had approximately 9 surgeries. He has no other medical problems.

Meds: Prednisone 10 mg PO QD
Lorazepam 2 mg PO TID
Metronidazole 250 mg PO TID
Loperimide 4 mg PO TID
Mesalamine 650 mg PO prn

Allergies: ASA products aggravate his Crohn's
Sulfa Drugs

Family History: States that his father suffered from a "deep depression" after the patient was diagnosed with Crohn's Disease in adolescence. States that his father spent a great deal of time in bed and isolated from others. Believes that his father's depression improved when the patient left home for college.

Social History: The patient was born in downstate Illinois and raised by his parents. He has one younger sister. He was educated through a Masters degree. He worked in a crime lab for several years. He has been in the corporate sector for 11 years. Currently is unhappy at his job and describes his boss as a "holy terror." He has been married for 5 years and currently lives with his wife and 15 month old son. Reports that his son was born 5 weeks premature but has been healthy.

Mental Status Exam: The patient was a well-groomed, appropriately dressed male who appeared his stated age. He was friendly and cooperative with good eye contact. He exhibited no psychomotor agitation or repetitive movements. His mood was depressed. His affect range was full. Speech was normal in rate and volume. Thought content included obsessions his son becoming ill or suffering an injury. There was no evidence of psychosis or suicidal or homicidal ideation. His thought process was coherent and goal-directed without any loosening of associations. He had good insight into his current situation and could eloquently explain his reasons for seeking help today. He was alert and oriented with intact cognition. His judgment was good.

Formulation: 37 year old man with long history of excessive anxiety and worry in various situations that he finds difficult to control. As a result of the anxiety, the patient has had sleep disturbance, difficulty concentrating, and has felt on edge. He meets diagnostic criteria for GAD. The patient has also had a marked and persistent fear of social contact or performance situations in which he might be embarrassed which meets the diagnostic criteria for Social Phobia. In addition, he has been depressed for several months, with crying spells, decreased sleep, and loss of interest in things. He most likely has a major depressive disorder. Lastly, he describes himself as being very anal and particular about how he does things. He sometimes obsesses about things such as the health of his son. Yet, he does not meet criteria for OCD. He most likely has obsessive compulsive personality traits.

Diagnoses:
Axis I: Generalized anxiety disorder, social phobia, major depressive disorder, recurrent, moderate
Axis II: Obsessive compulsive personality traits
Axis III:Crohn's disease
Axis IV: Stressful job, supportive wife, young child at home
Axis V: 70-80

Plan:

1. After discussing the therapeutic options, including the risks and benefits of various treatments, the patient elected to begin a trial of imipramine. We have started patient on imipramine 25 mg PO QHS to treat the anxiety disorder. It might also be beneficial in treating the depression and possibly the obsessive thoughts. Lastly, it might be helpful in treating the patient's diarrhea and pain.
2. Will gradually taper (by one mg per day) and then discontinue it.
3. Will obtain imipramine + desipramine blood level after a week, adjust dose accordingly
4. Will refer patient to a generalized psychiatric clinic for continued medication management.
5. Will refer the patient for Cognitive Behavioral Therapy.

_____ _____
XXXXXX XXXXXX, MD
Attending Psychiatrist

_____ _____
XXXXXX XXXXXXX, MD
Resident in Psychiatry