Case 2: 28 yo with decreased mental status

HPI
A 28 year old female with a history of seizures since childhood due to birth trauma was in her usual state of health until 5 days PTA at which time she stopped taking all of her medicatons except for her Tegretol, Valproic acid, and Ativan. Two (2) days PTA she began to experience vomiting, diarrhea, and a stomach ache. Mom treated her with Immodium. During the last 24 hours, she has been sleeping more and has not been interested in drinking or eating. She stopped talking anything on the day of admission.

LMP - 1 week ago which was normal. At baseline she talks, performs ADL's and lives in a handicapped apartment by herself.

Medications: Ativan 0.5mg BID, Valproic acid 500mg qAM/250mg qPM, Cogentin 1mg BID, Tegretol 400mg TID, Trilafon 8mg qHS, NSAIDs prn

Allergies: ASA

PMH
Seizure d/o since childhood from birth trauma
Suicidality (4 admissions to another facility within the past year)
s/p Lap. TL 3 yrs. ago

SH and ROS
Nonsmoker/drinker
Lives alone in apartments for the handicapped
Family visits often
Review of systems reveals recent 2-3 day h/o vomiting/diarrhea/abdominal pains. Mom denies cough, fevers, seizures, overdose, or recent surgery.

Physical Examination
General Appearance: Alert, nonverbal female who follows simple commands, responds to questions by squeezing hands.
VS: T 99.0 (t) HR 120 RR 20 BP 109/63 Pox 96% RA
HEENT: Perrl, Mouth dry,
Neck supple
LUNGS: CTA bilaterally.
CARDIAC: Tachy, regular, no murmurs
ABDOMEN: Soft, ND, NT. No guarding or rebound. Grimaces diffusely upon palpation
RECTAL: brown, ob negative
EXT: Good peripheral pulses; no edema
Skin: no rashes
NEURO: Moves all extremities to command, reflexes symmetric, CNS grossly symmetric