Paul A. Lambert, M.D.

1836 W Plaza Drive

Winchester, VA 22601

(540) 722-2280

**BLEPHAROPLASTY**

**PRE-OP INSTRUCTIONS:**

1. **Do not take aspirin, ibuprofen (Motrin, Advil), vit. E, or fish oil for at least two weeks before surgery. Coumadin also affects the clotting time of your blood. If you take Coumadin, please notify your physician, and he will adjust your medication as needed.**
2. Avoid SMOKING, and being around anyone who is smoking for two months prior to your surgery. Nicotine causes vasoconstriction of blood vessels, and increases your risk of post-operative complications.
3. Avoid sun exposure and tanning beds to the operative area for one month before surgery.
4. You must have a driver take you home. For your own comfort, plan to have someone stay with you for the first 24 hours. If you do not have someone to drive you home, YOUR SURGERY WILL BE CANCELED.
5. If you are being sedated, you must fast from **midnight** the night before surgery; not even coffee, gum, or mints in the morning.
6. Notify the Doctor if you routinely take any medications (i.e. for your heart, blood pressure, diabetes, seizures, or any herbal medications). If you do, take your medicine the morning of surgery with a small sip of water, or bring your medication with you the day of surgery.
7. If you use Retin-A, it should be discontinued one month before surgery. Retin-A increases circulation to the skin that could cause increased bleeding.
8. We advise you to purchase artificial tears to use post-operatively to relieve any dryness of the eyes. Artificial tears can be purchased at any drug store.
9. **Do not wear any make-up, contact lenses, or jewelry to the operating room.**
10. Wear loose, comfortable clothing. PLEASE LEAVE JEWELRY AND PERSONAL VALUABLES AT HOME!
11. Please notify our office at (540) 722-2280 if you have any of the following symptoms within two weeks of your surgery: FEVER, COUGH, COLD, NAUSEA, VOMITING, DIARRHEA, RASH, POISON IVY.

I acknowledge that I have read and understand the instructions stated above.

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_