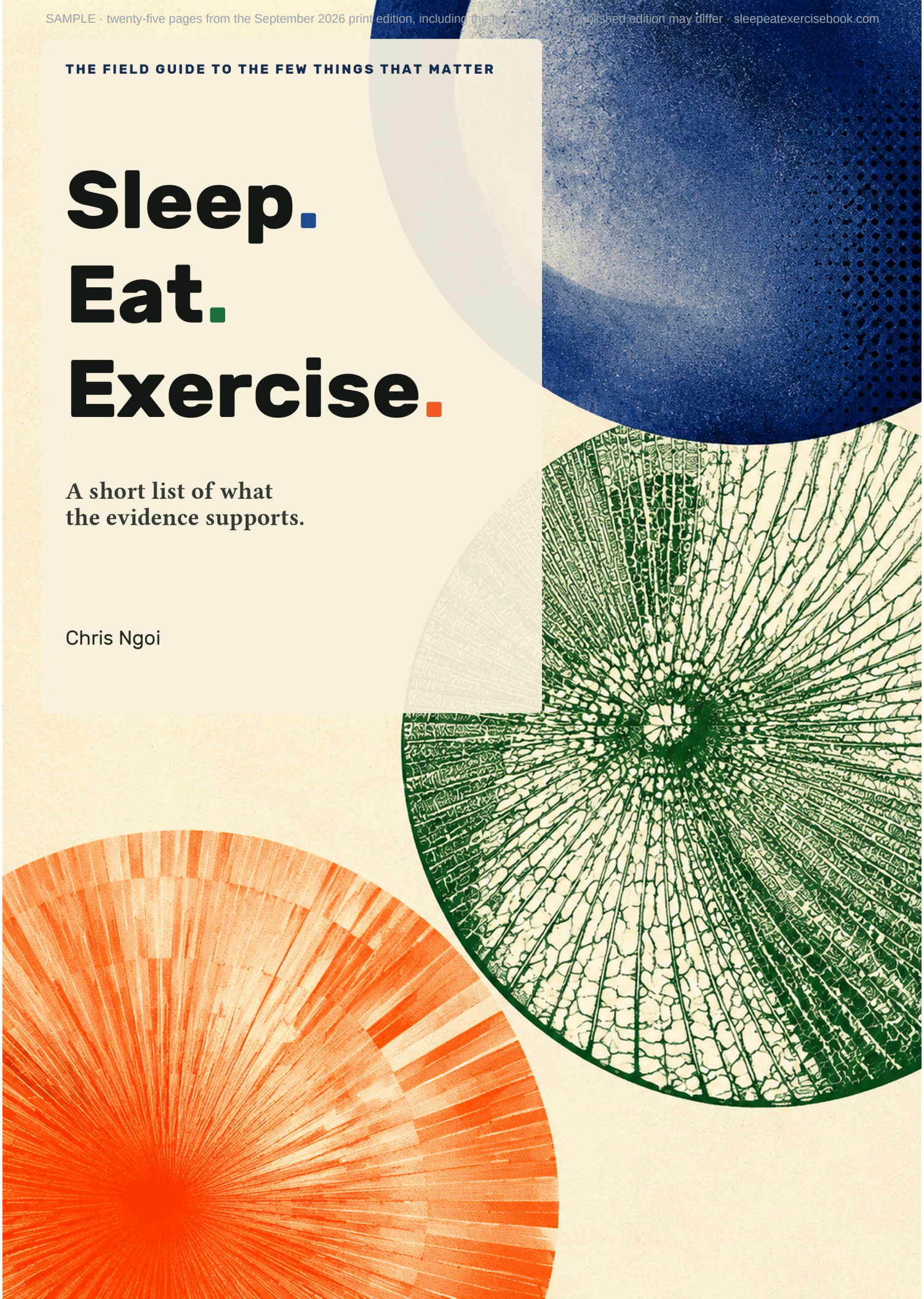
THE FIELD GUIDE TO THE FEW THINGS THAT MATTER

Sleep. Eat. Exercise.

A short list of what the evidence supports.

Chris Ngoi



Sleep. Eat. Exercise.

A short list of what the evidence supports.

Chris Ngoi

Foreword by Dr Daniel Mahadzir

First edition, 2026. Published by Chris Ngoi, Singapore. Printed on demand.

ISBN 978-981-94-7292-5 (hardback)
ISBN 978-981-94-7293-2 (paperback)
ISBN 978-981-94-7294-9 (ebook)

The disclaimers on page 5 govern every page of this book. Written with AI assistance; the cover image was generated with an AI tool.

Evidence checked to September 2026. Corrections and challenges: review@sleepeatexercisebook.com. Updates: sleepeatexercisebook.com.

FRONT MATTER · READ THIS FIRST

The disclaimers

One page. It governs every page that follows.

This is information, not medical advice	It is not a substitute for a doctor, a pharmacist or a nurse, and reading it does not put you in my care. Nothing here was written about you, because I do not know your history, your medicines or your conditions; the named people in the situations chapter are invented. Never start, stop or change a medicine because of this book. Where a page says something needs adjusting, treat it as a question for your doctor or your pharmacist. If the book contradicts your own clinician, they are right. Do not delay care because of anything you read here. If something worries you, get it looked at. The signs on page 126 come first: if one applies to you, act on that page and leave the rest of the book until you have.
The numbers are not universal, and they are for adults	Thresholds, doses, what is available on prescription and what you are legally obliged to report all differ by country. The book names the body behind each figure, so use the one that applies to where you live. None of the numbers were written for children; the one exception is the infant safe-sleep guidance in situation 12, which follows the AAP and Singapore's HealthHub. Where a page's advice needs adjusting for an age, a medicine or a condition, that adjustment sits on the page giving the advice. For anyone under 18, in pregnancy, or with a diagnosed condition, treat every number here as a question for someone who knows your history.
Written with AI assistance	AI tools helped me draft and edit the text. The ideas, frameworks, writing and final edits are mine. The cover image was generated with an AI tool.

IN SHORT

Nothing in this book is worth your health. If you are unsure, please ask someone who can examine you.

Five minutes

You do not have time to read a book about your health. This is a short one.

Your own health has quietly become the thing you never get to. You know the basics. Sleep more, eat better, and exercise more. The noise is louder than it was. Everyone has a view on cold plunges, peptides, and a shelf of supplements to go with it. Nobody tells you which part matters.

So I looked through the research. I pulled out the short list the evidence supports on outcomes that matter. Then I examined the hype and cut whatever did not survive. What is left is short on purpose. Five promises this book keeps:

- **No miracle supplement**
- **No glucose panic**
- **No anti-aging pill**
- **No 30-day fix**
- **No perfection required**

Who this is for. People with no time, who kept asking the same handful of things. What is the real stuff in all the noise? Where should they start? What can they trust? The answers turned out to be dull. Get up at the same time. Eat enough protein. Lift something twice a week. Walk more than you do.

Why believe any of it? Because of the method behind it. Almost every claim that rests on evidence is traced to its source and carries a grade for that source. Familiar advice and prescribing cautions carry none. If a grade looks generous to you, let me know and I will look into it.

Who wrote this, and where I sit. The book is my best-effort reading of the reviews, guidance and primary studies I could find to help people like me navigate how to sleep, eat and exercise better. This book recommends no brand or company, and sells nothing. In the chapters, a real name is a source being cited or a method being compared.

I am in the wellness industry, and you should not have to take my word for what that means: my work there includes sleep supplements, and overlaps directly with the supplement pages in this book. The overlap is printed here instead of left for you to discover. Nothing here was written to sell anything, and the no-product rule above covers my own. This book holds itself to the disclosure standard it asks of its sources.

And where it will be wrong. Some of what is here will not survive. Studies conflict, good ones get overturned by better ones, and a finding that looks solid at one sample size can shrink or vanish at a larger one. That is how the method works, and it is what separates it from the marketing this book exists to filter. Treat what follows as the best current reading and expect parts of it to age.

I am not a doctor, and I am not a researcher. That is the reason this book grades its evidence in the open rather than asking to be trusted.

> **WHERE TO GO NOW**
>
> To start today, your first week is on page 20. To find your situation, page 13. If something is worrying you, page 126 comes first.

FRONT MATTER · CONTENTS

What is in here

One hundred sixty pages, and you are not meant to read them in order. Set up the basics once, then use the situations when life lands on you. If something is worrying you, start on page 126.

FOUR WAYS IN

If you are facing a specific situation: page 13. If you only do one thing: page 20. If you are worried: page 126. If you take a regular medicine, or you are pregnant, speak to your doctor, pharmacist or midwife.

Three pillars, one system

Sleep, eat and exercise, wired into one loop.

SLEEP · WHERE TO START

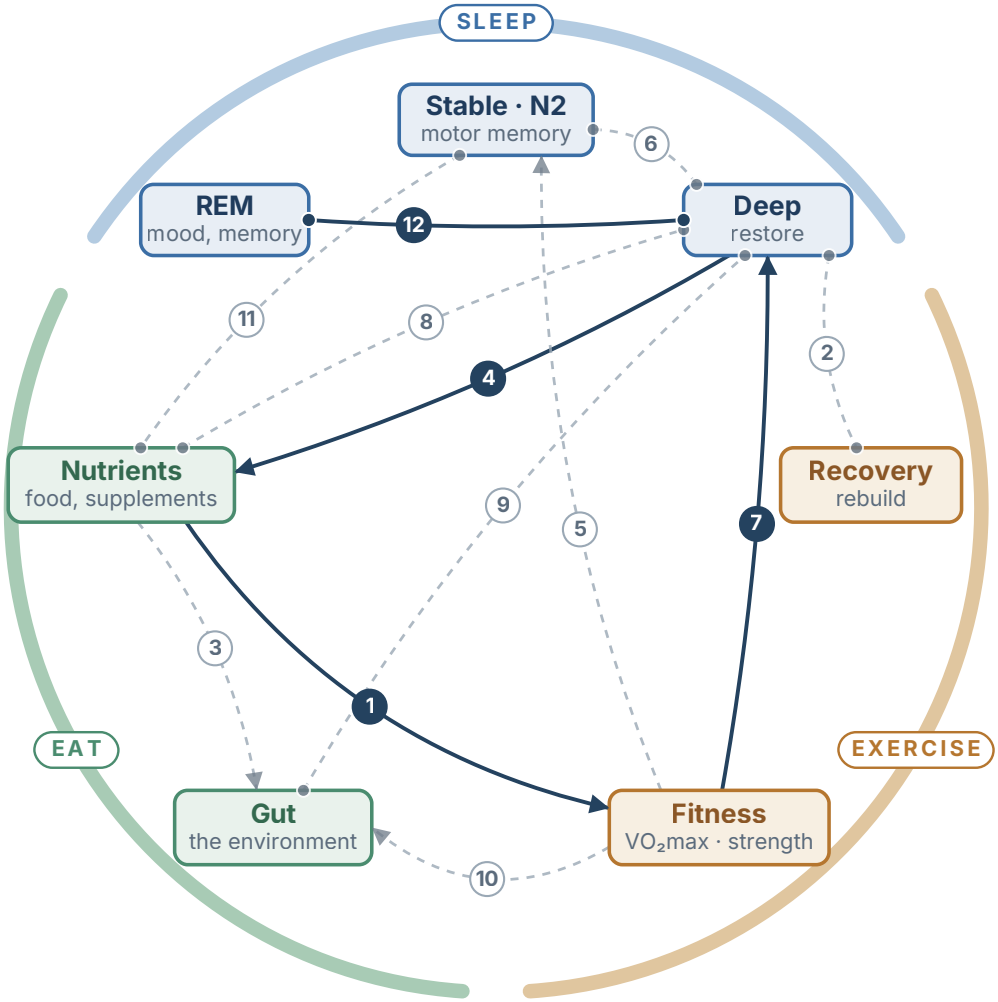
Start here: it needs no product, though protecting the time can be difficult, and it makes the other two easier to hold.

EAT · THE FUEL

Food first: protein and plants, unrefined by default.

EXERCISE · THE ENGINE

Train to last: strength, an easy base, banked by recovery.



Established or above · Emerging · tested direction · association, no direction tested

Every line joins two boxes. Numbers are the pathways, listed in the key.

All twelve pathways, drawn by how well each is evidenced

Four of the twelve reach Established or above and are drawn solid, and eight further pathways are drawn dashed. This is a reading map: an arrowhead marks a tested direction; a line with dots at both ends is an association, or the order of sleep stages, with no direction tested; and none of the lines means that changing one item will reliably improve the other.

ESTABLISHED OR ABOVE · SOLID LINES

1. Training with protein builds muscle
4. Longer sleep cut next-day intake
7. Training deepens slow-wave sleep
12. REM is back-loaded, so cutting the end of a night mostly cuts REM

EMERGING · DASHED LINES

2. The overnight growth-hormone pulse comes with sleep
3. Food shapes the gut: fiber and fermented foods
5. The day's practice is filed in stable sleep
6. Deep and stable sleep couple through the night
8. Higher fiber intake is associated with more deep sleep
9. Sleep and the gut track together
10. Exercise shifts the gut toward fiber-eating bacteria
11. Stable sleep tracks with next-day glucose control

IN SHORT

Your health is one interconnected system. The basics of sleeping, eating and exercising feed each other, and the strength of each link is graded above.

Start from what you notice

Set up the basics once. After that, this is the map. Find the line that sounds like your week and go to the page. More than one often applies, and where the moves overlap you only do it once. If something is worrying you, start on page 126.

What you notice	Where to go
I lie awake at 2am with my head running	Situation 1, page 98
Work has taken over and sleep went first	Situation 2, page 100
I crash every afternoon	Situation 3, page 102
I have let everything slide and want to start again	Situation 4, page 104
I fly, or work nights, and my clock is never right	Situation 5, page 106
I eat out most nights and cannot see how to fix it	Situation 6, page 108
I keep buying things that do not work	Situation 7, page 110
I am tired in a way sleep does not touch	Situation 8, page 112
I have a check-up booked, and I do not know what to ask for	Situation 9, page 114
A child, and no alarm, sets my mornings	Situation 10, page 116
I am well, but stairs and low chairs are getting harder	Situation 11, page 118
A new baby, and neither of us is sleeping	Situation 12, page 120
I sleep enough hours and still wake up tired	Page 126. Read that first
I am not sure where to start at all	Your first week, page 20, then sleep

FRONT MATTER · HOW TO READ THIS BOOK

How to read this book

Almost every claim in the source list from page 137 carries a grade, printed beside the entry. This is not a systematic review or a scientific grading methodology; it is one person synthesizing the research as I read it, and showing the working.

Grade	What it takes	The common misreading
Strong	Pooled randomized trials, or replication across many laboratories, large enough to settle the direction.	That Strong means settled for good. Even these get overturned, just less often.
Established	At least one well-conducted randomized trial, or a direction no longer in dispute.	It says how confident I am, and nothing about the size of the effect.
Moderate	Prospective cohorts, or several small or short trials. Most useful lifestyle evidence sits here.	Not a tier to skip.
Emerging	Mechanistic, cross-sectional or animal work, or one small trial on its own. Dashed on the map.	Limited confidence for the stated claim; the evidence may include human studies, and the limitation is in the entry.
Background	Reading that informs the argument without being a study. No grade.	A claim resting on it is marked as such.
Guidance	A clinical body, a regulator or a formulary sets the rule. The entry names which.	A kind of source rather than a rung; I have not re-graded what sits behind it.

How the studies were chosen, and why the advice boxes carry no grade

No systematic review and no pre-registered search. I started from the reviews and guidelines a clinician reaches for first, then worked back to the primary studies, preferring the largest and most recent pooling. Every dose and threshold was checked against the document it names, in 2026. What this misses: anything new, small, or outside the main journals. And the book does not grade pieces of common advice: a familiar claim is set beside what the evidence shows, and the reader weighs it. Every grade belongs to a source rather than to a piece of advice.

Three things to hold me to

(1) The grades are my judgments. They are informed by how GRADE handles certainty and by how Examine presents evidence; neither is affiliated with this book. This is not GRADE, because it rates each source rather than a body of evidence. Two rules I set

myself: publication bias caps a finding at Established, and I grade down a step where a smaller review disagrees with a larger one. Both are named in the entry.

(2) Almost every risk figure here is relative. Take two illustrative baselines over the same period: a 47% lower risk on 1 in 500 takes it to about 1 in 950; on 1 in 50, the same 47% is an absolute difference ten times as large. Relative figures are what the studies report, so they are what I print, and they overstate what any individual should expect. Hold the direction, and let the size of the gain follow your own baseline.

(3) Curves with no plotted points are marked schematic. They show the shape of a finding. Where a chart carries real numbers, those numbers are in the sources like everything else.

> **TEN SOURCES FIRST**
>
> If you read only ten sources, read these: Windred 2024 on regularity, Gardiner 2023 on caffeine, Qaseem 2016 on CBT-I, Reynolds 2019 on fiber, Morton 2018 on protein, the AHA Presidential Advisory on fat, Momma 2022 on strength, Ding 2025 on steps, Sherrington 2019 on balance, and Hagger 2016 on willpower. Every one is in the source list with its grade.
> Their DOIs, in that order, so the paper copy stands on its own: 10.1093/sleep/zsad253; 10.1016/j.smrv.2023.101764; 10.7326/M15-2175; 10.1016/S0140-6736(18)31809-9; 10.1136/bjsports-2017-097608; 10.1161/CIR.0000000000000510; 10.1136/bjsports-2021-105061; 10.1016/S2468-2667(25)00164-1; 10.1002/14651858.CD012424.pub2; 10.1177/1745691616652873. Each checked on PubMed.

DO THIS FIRST

Three tools to get started

Everything before this explains the book. These three tools are for anyone who wants the key takeaways of the book. The first is the whole book, on one page, with the studies behind it on the page after. The second is the order to add things in, one line to start and the rest over months. The third is where you are today, so that a year from now you can read a direction straight off it.

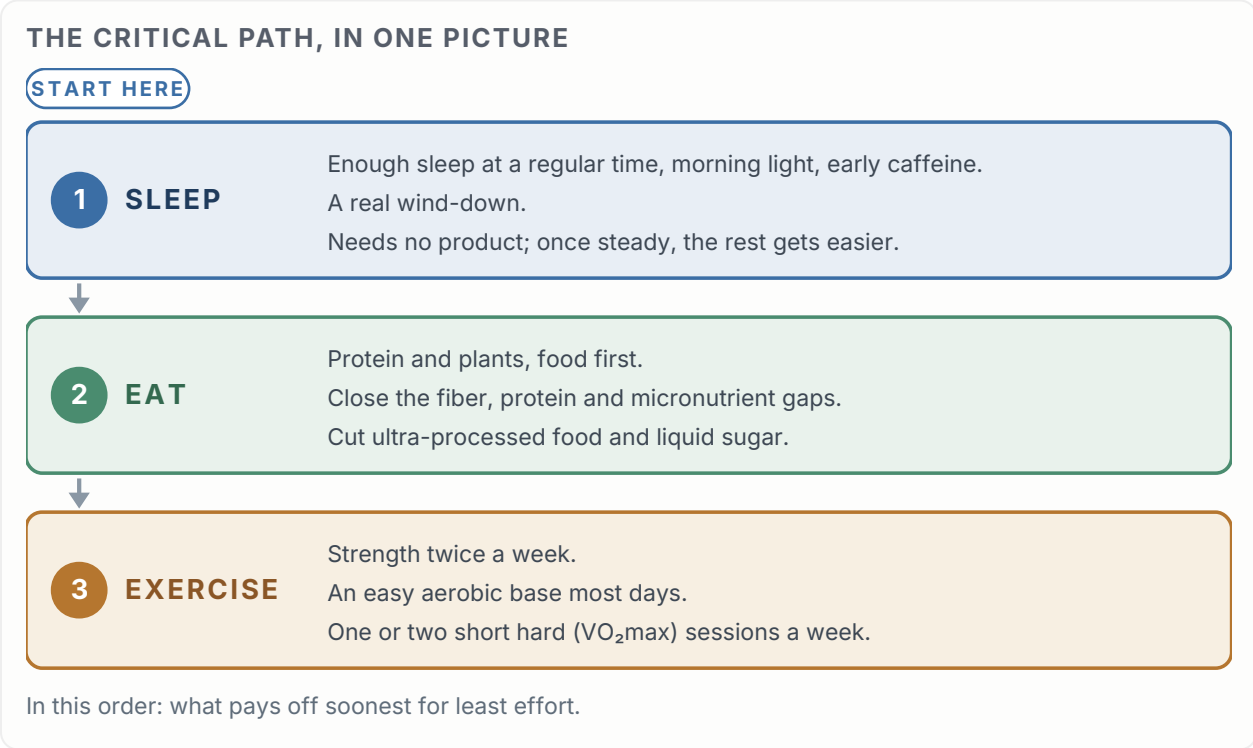
WORRIED ABOUT SOMETHING NOW? PAGE 126 COMES FIRST.

DO THIS FIRST · THE CRITICAL PATH

The whole book, on one page

Start with these three, in this order. It is ordered based on what I think pays off soonest for least effort.

- [ ] **Sleep.** Enough sleep at a regular time, morning light, last caffeine early, a real wind-down. Start here. It needs no product, though protecting the time can be difficult, and the rest gets easier once it is steady. After real sleep loss, recovering it comes before the clock (page 33).
- [ ] **Eat.** Build meals on protein and plants. Close the fiber, protein and micronutrient gaps with food first. Cut ultra-processed food and liquid sugar.
- [ ] **Exercise.** Strength twice a week, an easy aerobic base most days, one or two short hard (VO_2max) sessions a week.



These habits are worth working on for health and daily functioning. Long-term studies associate healthier lifestyles with longer lives, but they cannot say how many years this particular plan would add. The studies behind that sentence, and what they can and cannot promise, are on page 19.

> **IN SHORT**
>
> Sleep first, then the plate, then the training. Everything after this page is detail and exceptions.

What the lifespan studies say

The number people quote for healthy habits, where it comes from, and how to read it.

The number people quote comes from one study. Li and colleagues followed around 123,000 people in two long-running US cohorts for up to three decades, and the question was simple. How much life expectancy comes with five plain factors held together? Five factors: (1) never smoking, (2) a healthy weight, (3) 30 minutes of daily activity, (4) moderate alcohol, and (5) a better-than-average diet.

Li does not split the years by factor. At age 50, women with all five had roughly 14 more years of life expectancy than women with none, and men roughly 12 (**Li 2018**). Observational, so it is an association rather than a promise. People who keep all five differ in other ways too.

LI 2018, OBSERVATIONAL: LIFE EXPECTANCY AT 50 WITH NONE VS ALL FIVE OF NEVER SMOKING, HEALTHY WEIGHT, DAILY ACTIVITY, MODERATE ALCOHOL, BETTER DIET

Sleep is not one of the five, and an association in a cohort is not a promise about this plan.

What that means for how you read this book. None of the five is exotic, and none of them is on a supplement shelf. People who stacked them showed the largest difference, and no single item does it on its own. The three are one system. Modest gains across all three tracked with longer life. In the UK Biobank analysis behind that line, the gap between the best and worst sleep, diet and activity combinations came to almost a decade of life (**Koemel 2026**). That is an estimated gap between groups rather than years this plan adds.

Note the honest wording on the alcohol category. It was defined as moderate drinking, 5 to 15 g a day for women and 5 to 30 for men, so abstainers did not score on it. That is the same design problem Zhao 2023 identifies, sitting inside the score. Read the fourteen years as an association that confounding could move either way.

> **IN SHORT**
>
> Read the figure as the size of the association around basic habits, and how stacking them tracks with a meaningful difference.

Sources: five factors and lifespan, Li Circulation 2018; the abstainer problem, Zhao 2023; modest combined gains, Koemel 2026 (eClinicalMedicine, UK Biobank, n=59,078).

DO THIS FIRST · YOUR FIRST WEEK

Your first week

Habits take months to hold, with wide variation (page 90). Start with sleep, marked below. It is the first line of the pillar that multiplies the other two: sleep sets up the food and the training, and they feed back into deeper sleep.

SLEEP · THE BASE · START HERE

- [ ] **Enough sleep, at a regular time. START HERE.** Aim for enough sleep and a reasonably regular schedule. A steady wake time with ten minutes of daylight is the easiest end to hold (ten minutes is my rule), but do not keep cutting sleep to protect the clock: after real sleep loss, make room to recover it (page 33). This is the whole assignment for week one; everything below it can wait.
- [ ] **Wind-down.** Screens down half an hour before bed (a convention). Keep the room cool and dark.
- [ ] **Cutoffs.** Leave about nine hours between a mug of coffee and bed. That is a population starting point, and people vary widely. Gardiner 2023 pooled 24 studies: 8.8 hours for a 107 mg coffee, and 13.2 hours for a 217.5 mg pre-workout scoop. Up to about 400 mg a day is the level EFSA treats as safe rather than a target, and under 200 mg in pregnancy. Doses vary by drink and brand, so read any figure as approximate. No alcohol within three hours (a convention). Longer after more than one drink. With sleep apnea, leave the evening drink alone: it worsens the airway.

EAT · THE FUEL

- [ ] **Protein + plants.** For every meal, make sure you have a palm of protein and half a plate of vegetables.
- [ ] **Cut liquid sugar.** Remove sugary drinks from your diet, unless one is treating a low blood sugar.
- [ ] **Feed the gut.** I recommend adding one fermented food a day (the trial behind it used about six servings; one is my rule). Reach for plants at most meals.

EXERCISE · THE ENGINE

- [ ] **Strength.** Two sessions of about 30 minutes, my working length, in slots you pick now: a push, a pull, a squat.
- [ ] **Daily base.** A short walk after lunch, and stand and move once every half hour of sitting (a convention).
- [ ] **Go hard once a week.** One short hard effort: hills, stairs, or brisk intervals. Build the easy base first. Any heart condition or symptom on exertion means checking with your doctor first (see page 126).

MEASURE · THE BASELINE

- ☐ **Numbers.** Write down your waist measurement with today's date, and check which screening is due.
- ☐ **Self-test.** Try the free fitness tests, beside something you can grab, with someone nearby: (1) stand on one leg, (2) sit down on the floor and stand back up, using a hand or a chair if you need to; the point is the trend. If you are unsteady or dizzy, skip them and ask your doctor. Both track with survival in cohort studies (**Araujo 2022, 2025**).

MARK A DAY, EVERY DAY

One mark for a day you got enough sleep at about your usual time, and nothing else; a recovery night after sleep loss counts. Where you keep it is up to you. Seventy boxes is what I use; the median habit took about 66 days, with wide variation. The effect depends on a record you can see (page 92), so put this where you walk past it.

1	2	3	4	5	6	7	8	9	10	11	12	13	14
15	16	17	18	19	20	21	22	23	24	25	26	27	28
29	30	31	32	33	34	35	36	37	38	39	40	41	42
43	44	45	46	47	48	49	50	51	52	53	54	55	56
57	58	59	60	61	62	63	64	65	66	67	68	69	70

> **IN SHORT**
>
> For week one, check off enough sleep at a regular time; add a food or movement habit when that feels manageable. Ask your clinician how these apply if you take a regular medicine, are pregnant, or have a diagnosed condition.

DO THIS FIRST · WRITE IT DOWN ONCE

Where you are today

Four numbers, one date, ten minutes. The point is the comparison you make later.

Everything in this book is a trend. Write these down, put the date on them, then close the book and focus on sleeping, eating and exercising better.

FIRST, THOUGH

Four things to do before you optimize anything. None gets a chapter here, because none of them is what this book is about: (1) not smoking, (2) keeping your blood pressure treated, (3) taking the screening you are offered, and (4) your vaccinations.

	TODAY	A YEAR LATER
DATE		
WAIST, RIB TO HIP MIDPOINT cm or inches, on bare skin, breathing out, halfway between your lowest rib and your hip bone		
BLOOD PRESSURE from a pharmacy or a clinic: sit five minutes, then two readings (a convention)		
GET OFF THE FLOOR two hands, one hand or none, with someone nearby; unsteady or dizzy, skip these and ask your doctor		
STAND ON ONE LEG, EYES OPEN how many seconds, beside something you can grab		

THE WAIST RULE, AND ONE WARNING

A rule that needs no table: if your BMI is under 35, NICE says keep your waist under half your height. A waist above that ratio is where risk climbs. If counting food or measuring your body feels compulsive, skip the numbers and get support; the habits without numbers still work. Nothing here is a daily test.

WHAT THESE NUMBERS WILL AND WILL NOT TELL YOU

No fitness test here predicts your future on its own, and no single reading means much. Waist and blood pressure are the two I would keep if I could keep only two. The tests are here because they are easy to do and cost almost nothing.

If a number comes back clearly abnormal, that is a conversation with your doctor, and screening intervals follow age, risk and history rather than the calendar, so ask which is due and when. The warning signs are on page 126.

Sources: waist under half your height, NICE NG246 (overweight and obesity management).

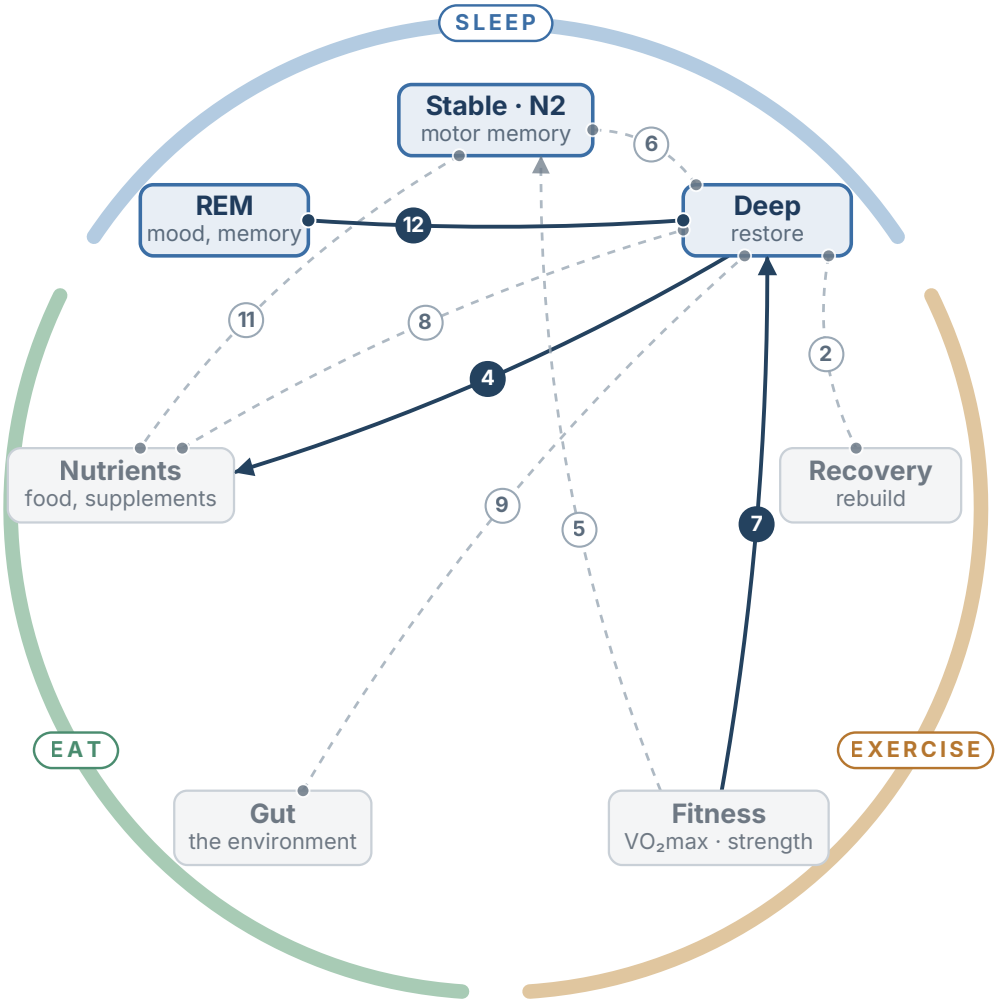
SLEEP · START HERE

What matters most in a night

REMEMBER THIS **Protect a full, dark, cool night on a steady clock.**

7-9 h asleep	**±30 min** same wake time	**18-19°C / 64-66°F** dark room; warmer past age 65
0 alcohol within 3 h of bed	**~9 h** coffee-to-bed gap	**~30 min** wind-down

Working rules rather than trial results: temperature, alcohol gap, wind-down, wake window. Caffeine gap, pooled trials; 7 to 9 h, guidance.



Every line joins two boxes. Numbers are the pathways, listed in the key.

Where sleep sits: the nine pathways that run through the night

ESTABLISHED OR ABOVE · SOLID LINES

4. Longer sleep cut next-day intake
7. Training deepens slow-wave sleep
12. REM is back-loaded, so cutting the end of a night mostly cuts REM

EMERGING · DASHED LINES

2. The overnight growth-hormone pulse comes with sleep
5. The day's practice is filed in stable sleep
6. Deep and stable sleep couple through the night
8. Higher fiber intake is associated with more deep sleep
9. Sleep and the gut track together
11. Stable sleep tracks with next-day glucose control

WHY SLEEP GOES FIRST

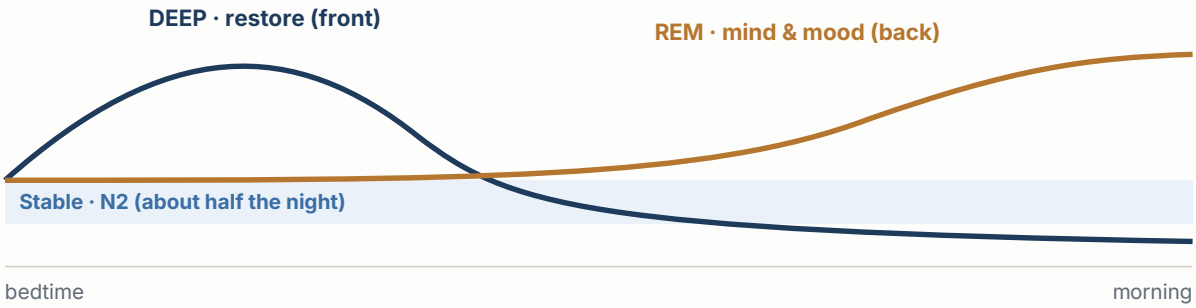
Sleep goes first: it needs no product, though protecting the time can be difficult, and it makes the other two easier.

SLEEP · START HERE · THE NIGHT, AND THE LOOP

A night is not one thing

A night runs in cycles of roughly ninety minutes, and each cycle is weighted differently depending on where in the night it falls. Stable sleep (N2) is about half the whole night, linked to filing the day's skills between the deeper stages. Deep sleep is front-loaded into the first third, alongside a growth-hormone pulse that comes with sleep rather than with the stage. REM is back-loaded and grows toward morning, linked to sorting memory and settling mood. The chapters below take them in that order.

ANATOMY OF A NIGHT: THREE KINDS OF SLEEP, CYCLING SCHEMATIC



How the night touches everything else. The map that opens this part shows what connects to what, and how well each line is evidenced. Sleep is where the day's training becomes repair, through the overnight growth-hormone pulse (link 2, dashed). It also steadies the next day's appetite (link 4), and after a run of short nights the plate gets harder to get right. What the studies measure is intake rather than appetite. Stable sleep is linked to filing the motor skill you practiced that day (link 5), and its spindles couple with deep sleep to consolidate memory (link 6). Traffic runs the other way too: training deepens slow-wave sleep (link 7), higher fiber intake is associated with a little more (link 8), and sleep and the gut track together (link 9). Nine of the twelve pathways in this book touch the three sleep boxes.

Sources: stage percentages and architecture, Ohayon 2004 (meta, 65 studies), Carskadon & Dement 2017; regularity out-predicts duration, Windred 2024; duration, Cappuccio 2010 & Yin 2017.

A fixed wake time

Most sleep advice is about the hour you go to bed. Regular timing tracks better outcomes in the strongest data here. That link is observational. A fixed wake time is the practical anchor, the easiest end to hold.

And about naps

One trial compared nap lengths from five to thirty minutes. Ten minutes worked from the moment people woke. A twenty-minute nap took about thirty-five minutes to pay off; a thirty-minute nap left people groggy first (**Brooks & Lack 2006**, 24 adults after a short night). It could not measure what a nap costs the next night, since every night in it was cut to five hours. A nap late in the day borrows pressure from tonight (a convention). Needing a nap most days despite seven to nine hours in bed is not a napping question. See the warning signs on page 126.

What sleep consistency looks like

ONE WAKE TIME, SEVEN DAYS SCHEMATIC

Same time within about half an hour, on nights that were long enough. The half hour is a rule of thumb, and recovery sleep comes first.

The tested part is the tracker cohort on page 29: irregular timing tracked worse outcomes (**Windred 2024**). When you are short of sleep, sleep comes first, whatever the clock says; that matters most if you drive or do safety-critical work. To recover sleep, go to bed earlier and keep your wake time where you can. Whether catching up later helps is unsettled. One accelerometer cohort found short sleep followed by rebound did not carry the higher mortality short sleep without rebound did (**Li 2026**). Another in the same biobank found weekend catch-up tracked with nothing (**Chaput 2024**).

Two caveats come with it. (1) I could not find the trial that would settle it, since randomizing people to a fixed or a drifting wake time is unlikely to be run. (2) Regularity is easier to hold if your life is settled. Some of what the study measured may be a marker of a settled life as much as a cause of a longer one.

When life gets in the way. On a wrecked week, do not try to hold everything. If you are running a real deficit, get the sleep first, and count that as the plan working. Otherwise protect one thing: the wake time. Once the week eases, a steady clock lets morning light, meals and training fall back into place.

When it has gone on too long

Clinicians call one pattern insomnia disorder: sleeping badly three or more nights a week for three months or more, with the chance to sleep and a cost by day. It is a reason to get assessed.

The treatment with the best evidence is a short course of cognitive behavioral therapy for insomnia, four to eight sessions. The American College of Physicians and the sleep academy put it ahead of medication (**Qaseem 2016**; **Edinger 2021**). Name CBT-I when you ask. One automated self-help course has been assessed by NICE for NHS use in adults with insomnia (HTG624). That is an assessment for a health service rather than a trial result.

Two things before starting. (1) CBT-I comes in three forms: clinician-delivered, guided digital, and self-help. The trial evidence is strongest for the first two; among self-help, the automated course NICE assessed is the exception. Ask which format and level of support suits your situation. One core component, sleep restriction, makes most people sleepier for a few weeks before it helps (**Kyle 2014**). (2) That stretch of sleepiness is riskiest with bipolar disorder or epilepsy, or if you drive for a living, so whoever supervises needs to know. The protocol detail is convention, and the contraindications are a prescribing caution.

> **THE ONE TO KEEP**
>
> Hold the wake time within about half an hour on the days the night was long enough (a convention). After a short night, the extra sleep comes first; it is the sleeping in without a deficit that drifts the clock.

Sources: regularity, Windred 2024; naps, Brooks & Lack 2006; catch-up sleep, Li 2026, Chaput 2024; CBT-I, Qaseem 2016, Edinger 2021; sleep restriction, Kyle 2014.

When to get it looked at

This is not an exhaustive list of reasons to get checked; these are the signs I kept meeting in the research that I would get seen for by a qualified professional. If something worries you and it is not here, get it looked at.

EMERGENCY: CALL FOR HELP NOW

Do not wait. Where a line names no other action, call: an ambulance (995 in Singapore, 911 in the US) or an emergency department; tell someone, and do not drive yourself. Crisis lines, any hour: US 988, Singapore 1767, elsewhere findahelpline.com. Cannot be woken, or a seizure: call.

- Thoughts of harming yourself, or that life is not worth living: a crisis line now, or 995/911 if you cannot keep yourself safe
- On insulin or a sugar-lowering medicine, and shaky, sweating or confused: if you can swallow safely, follow your hypo plan now; if not, call, say it may be a hypo, and give nothing by mouth
- Pregnant or within a year of birth: severe headache, visual change, pain below the ribs or feeling very unwell: go in now, before measuring anything; say when the birth was (NG133)
- Vomited blood, black stools with faintness, or heavy bleeding; severe belly pain with vomiting, a swollen belly, or no stool or wind passing (NHS)
- Chest pain happening now, at rest or not easing; sudden severe breathlessness
- Calf pain or swelling with breathlessness, chest pain or coughing blood
- In the weeks after birth: confusion, agitation, hallucinations, impossible beliefs, or thoughts of harming the baby: call now and stay until help arrives
- On a gliflozin, and feeling sick, vomiting, breathing deep and fast, or with stomach pain
- Face drooping, arm weakness or slurred speech, sudden: ambulance now (NHS)
- Fighting to stay awake at the wheel: stop somewhere safe now; no driving while the sleepiness lasts
- After heat, a hard session or on a statin: severe unexpected muscle pain, weakness, or cola-colored urine, any one (CDC)

URGENT: SAME DAY

Seen the same day, my rule; at 180/120 NICE asks for organ checks as soon as possible. Anything severe, or feeling very unwell: the emergency list.

- Thirst and passing a lot of urine, with blurred vision or weight loss; with vomiting or deep fast breathing, the emergency list
- Chest pain, breathlessness or dizziness that comes with exertion and settles with rest; happening now, the emergency list
- Blood pressure 180/120 mmHg or higher, either number; with symptoms, the emergency list
- Black stools; with faintness or vomited blood, the emergency list above
- Pregnant, and a reading of 140/90 mmHg or above, either number: call your maternity unit; 160/110 or above, either number: go in now (NG133)
- Calf pain or swelling after a long flight, surgery or illness

WORTH A CALL THIS WEEK

- Blood in your stool, persistent pain, weight loss or a changed bowel habit; with diverticular disease, worsening pain, blood or mucus, or a fever is the same day (NHS)
- An urge to move your legs at night, worse at rest, eased by moving: ask about restless legs; iron testing is the clinician's call
- Snoring, gasping, or waking unrefreshed however long you sleep: ask about sleep apnea
- Sleep attacks, sleep paralysis with daytime sleepiness, knees buckling when you laugh, or physically acting out your dreams: ask to be assessed, narcolepsy by name for the first three
- Low mood, anxiety or loss of interest running for weeks
- Sleep, mood, memory and periods all changed in one year: ask about perimenopause by name; before 45, what else it could be
- Unexplained, persistent or worsening fatigue: get assessed without finishing this plan first, and say if you menstruate
- Home blood pressure repeatedly 135/85 mmHg or above, either number; fasting glucose reaching 7 mmol/L (126 mg/dL) or HbA1c 48 mmol/mol (6.5%)
- Trouble sleeping three or more nights a week for three months: ask for CBT-I by name
- Measuring, counting or eating feels compulsive
- Drenching night sweats with fever or weight loss

IN SHORT

Thresholds follow WHO criteria, NICE NG136 and NG133, and the AASM; stroke signs, the NHS; muscle signs, the CDC. One reading is rarely a diagnosis.