Age planning and when to start trying based on age

Why age matters in pregnancy planning

Age is one of the strongest predictors of natural fecundability, meaning the chance of conceiving in a single menstrual cycle. For people with ovaries, fertility depends partly on ovarian reserve, the remaining pool of follicles, and oocyte competence, the ability of an egg to mature, fertilize, and contribute to a chromosomally normal embryo. Both tend to decline with age.

This decline is not sudden at a birthday, and it varies from person to person. However, population-level patterns are consistent: fertility begins to decline gradually in the early 30s, declines more significantly after 35, and becomes substantially lower by the early 40s. As age increases, the proportion of eggs with chromosomal abnormalities also increases, which contributes to lower implantation rates and higher miscarriage risk.

Age does not mean pregnancy is impossible. Many people conceive healthy pregnancies in their late 30s and 40s. But planning becomes more time-sensitive, and waiting a full year before asking for help may not be the best approach for everyone.

If you are in your 20s: time is usually more flexible, but preparation still

matters

In the 20s, natural fertility is generally at its highest, and many people who have regular intercourse during the fertile window conceive within a year. If your cycles are regular and there are no known reproductive or medical issues, it is usually reasonable to try for up to 12 months before seeking an infertility evaluation.

That said, age alone should not be the only factor guiding your plan. Consider a preconception visit before trying, especially if you take prescription medications, have a chronic condition such as diabetes, hypertension, thyroid disease, epilepsy, autoimmune disease, kidney disease, or a history of depression or anxiety. Medication review is particularly important because some drugs should be adjusted before conception, while others should not be stopped abruptly.

Earlier evaluation may be appropriate in your 20s if you have very irregular or absent periods, suspected anovulation, endometriosis, prior pelvic inflammatory disease, a history of ectopic pregnancy, known uterine or tubal disease, chemotherapy or pelvic radiation exposure, or a partner with known sperm abnormalities. In those situations, waiting a full year may delay useful care.

If you are 30 to 34: consider your desired family size and timeline

Between 30 and 34, many people still have a good chance of conceiving naturally, but fertility may begin to decline gradually. This is a useful age range for strategic planning, especially if you hope to have more than one child. Time to conception, pregnancy duration, postpartum recovery, breastfeeding goals, and spacing between pregnancies can all affect whether your preferred family size is biologically realistic.

If you are ready for pregnancy in this age range, starting sooner rather than later may preserve more options. If you are not ready but know you want children in the future, a preconception or fertility counseling visit can help you understand your baseline health, menstrual pattern, and potential risk factors. Some people may also wish to discuss ovarian reserve testing or fertility preservation, recognizing that ovarian reserve tests estimate quantity more than egg quality and do not guarantee future fertility.

For people under 35 with regular cycles and no known risk factors, many guidelines use 12 months of trying as the point to seek evaluation if pregnancy has not occurred. However, if your cycles are consistently shorter than 21 days, longer than 35 days, unpredictable, or absent, it is better to ask for help earlier because ovulation may not be occurring regularly.

If you are 35 to 39: start when you feel reasonably ready and seek help sooner

At 35 and older, fertility decline becomes more clinically significant. This does not mean you must rush into pregnancy before you are emotionally or practically ready, but it does mean that the cost of long delays is higher. If pregnancy is a near-term goal, it is often sensible to begin trying once your major medical and personal preparations are in place.

A common recommendation is to seek fertility evaluation after 6 months of regular, unprotected intercourse if pregnancy has not occurred by age 35 or older. The reason is not that 6 months is abnormal in every case; rather, it helps avoid losing time when age-related egg quantity and quality are already declining more quickly.

It can also be helpful to schedule a preconception visit before you start trying. A clinician may review vaccination status, medications, folic acid or prenatal vitamin use, chronic disease optimization, menstrual history, prior pregnancies, body weight, substance exposure, and genetic carrier screening options. If there are concerns such as endometriosis, fibroids affecting the uterine cavity, prior tubal surgery, recurrent miscarriage, or a partner with sperm risk factors, referral may be recommended earlier than 6 months.

If you are 40 or older: consider early consultation, even before trying

Pregnancy after 40 is increasingly common, but natural conception rates are lower and miscarriage rates are higher than at younger ages. Ovarian reserve is usually reduced, and the proportion of chromosomally abnormal eggs is higher. Because time is especially valuable, many reproductive specialists advise consultation before trying or soon after starting if you are 40 or older.

An early consultation does not commit you to treatment. It may simply clarify

your options, including timed intercourse, ovulation assessment, semen analysis for a male partner, tubal evaluation when indicated, or assisted reproductive technologies such as in vitro fertilization. For some people, donor eggs, donor sperm, embryo donation, or gestational carrier arrangements may become part of counseling, depending on medical circumstances and local laws.

Age 40 and beyond also increases the importance of medical optimization before pregnancy. Risks such as hypertensive disorders of pregnancy, gestational diabetes, cesarean birth, placenta-related complications, and chromosomal conditions are more common with advancing maternal age. These risks do not mean pregnancy should be avoided automatically, but they do justify individualized preconception and obstetric planning.

How to time trying: fertile window basics

Regardless of age, timing intercourse or insemination around the fertile window improves the chance of conception. The fertile window includes the days leading up to ovulation and the day of ovulation. Sperm can survive for several days in fertile cervical mucus, while the egg is viable for a shorter period after ovulation.

For many couples, intercourse every 2 to 3 days throughout the cycle is a practical approach that avoids the stress of perfect timing. Others prefer ovulation predictor kits, cervical mucus tracking, basal body temperature charting, or cycle-tracking apps. These tools can be useful, but they are not equally reliable for everyone, especially with irregular cycles, polycystic ovary syndrome, postpartum cycles, perimenopause, or recent hormonal contraceptive use.

If tracking becomes emotionally exhausting, it is reasonable to simplify. The goal is not to make every cycle feel like a test of discipline. Regular intercourse in the fertile window is helpful, but fertility is also affected by factors that timing alone cannot overcome, such as tubal blockage, severe male factor infertility, diminished ovarian reserve, or anovulation.

When to seek medical help if pregnancy does not happen

General timeframes can help, but they should be adapted to your history. A

typical approach is:

Under 35: seek evaluation after 12 months of regular, unprotected intercourse if pregnancy has not occurred.
Age 35 to 39: seek evaluation after 6 months of trying.
Age 40 or older: consider evaluation before trying or soon after starting.
Any age: seek earlier care if there are irregular or absent periods, known endometriosis, prior pelvic infection, suspected tubal disease, recurrent pregnancy loss, prior cancer treatment, or known sperm concerns.

A fertility evaluation may include a detailed history, confirmation of ovulation, ovarian reserve markers such as anti-Mˆ…llerian hormone or antral follicle count, thyroid or prolactin testing when indicated, assessment of the uterus and fallopian tubes, and semen analysis. The exact workup should be individualized by a qualified clinician.

Seeking help is not a failure, and it does not mean you will need advanced treatment. Sometimes evaluation identifies a correctable issue; sometimes it provides reassurance; and sometimes it helps you make timely decisions about treatment options.

Planning when you are not ready yet

If you know you want children but are not ready now, it can be emotionally difficult to balance real-life constraints with biological timelines. A useful first step is to define your likely earliest start date, desired number of children, and whether you would consider fertility preservation or assisted reproduction if needed.

Egg freezing may be an option for some people delaying pregnancy, and success is generally better when eggs are frozen at younger ages. However, it is not an insurance policy. Outcomes depend on age at freezing, number of mature eggs stored, laboratory quality, future sperm factors, uterine health, and overall medical circumstances. Embryo freezing may be considered when sperm is available and the person is comfortable creating embryos.

For couples or individuals delaying until the late 30s or 40s, a counseling visit with an obstetrician-gynecologist, reproductive endocrinologist, or

fertility specialist can be useful even if you are not ready to act immediately. The aim is to understand options and limitations, not to pressure you into a decision.