Chances of getting pregnant by age and how fertility decline affects probability

What "chance of getting pregnant" means medically

When clinicians and researchers talk about the chance of getting pregnant, they often use the term fecundability: the probability of conception in a single among people having intercourse without contraception. This is different from fecundity, which refers more broadly to the biological capacity to achieve a live birth.

Monthly probability is not the same as cumulative probability. For example, a couple may have a modest chance in any one cycle, but the chance of conceiving accumulates over repeated cycles. This is why many healthy couples do not conceive immediately but do conceive within several months. It is also why age-related decline matters: a smaller monthly probability means fewer pregnancies over time, even if intercourse timing is appropriate.

Research from a North American preconception cohort found that fecundability declined with increasing female age, with women aged 40-45 having substantially lower conception probabilities than younger women. The study also noted that factors such as intercourse frequency and cycle regularity influence observed pregnancy chances, which is a useful reminder that age is important but not the only variable.

Approximate monthly chances of pregnancy by age

Different studies produce slightly different estimates because they include different populations, definitions, and methods. Still, the overall pattern is consistent: the average chance of conception per cycle is highest in the 20s and early 30s, begins to decline more noticeably in the mid-30s, and falls more sharply after 40.

20s to early 30s: Many sources estimate that the chance of pregnancy in a cycle with appropriately timed intercourse is roughly 20-25% for many healthy couples.
Mid-30s: Fertility begins to decline more clearly. A person may still conceive naturally, but the monthly probability is lower than in the 20s.
Late 30s: The decline becomes more clinically significant, and the time to pregnancy often lengthens.
Age 40 and beyond: Natural conception remains possible, but the average monthly chance is much lower, and miscarriage and chromosomal risks are higher.

Your Fertility, an educational resource, summarizes that women younger than 30 have about a 20% chance of pregnancy each month, around age 40 the monthly chance is closer to 5%, and fertility declines more rapidly after the mid-30s. These are averages, not predictions for a specific person.

Why fertility declines with age

The main biological reason fertility declines with age is ovarian aging. People with ovaries are born with a finite number of oocytes. Over time, both the quantity and quality of remaining eggs decline. Egg quantity is often discussed in terms of ovarian reserve, which can be assessed indirectly with tests such as anti-Mˆ…llerian hormone, antral follicle count, and follicle-stimulating hormone. These tests can provide useful information, but they do not perfectly predict whether someone will conceive naturally in a given month.

Egg quality refers largely to whether an egg has the correct chromosomal content and enough cellular competence to fertilize, develop into an embryo, implant, and continue as a healthy pregnancy. As age increases, a higher proportion of eggs are aneuploid, meaning they have an abnormal number of chromosomes. Aneuploid embryos are less likely to implant and more likely to

result in early pregnancy loss.

Age can also influence ovulation regularity and cycle predictability. In the later reproductive years, cycles may shorten, ovulation may occur earlier, and some cycles may be anovulatory. These shifts can make it harder to identify the accurately, particularly for people relying only on calendar estimates.

Age, miscarriage risk, and chromosomal conditions

Pregnancy probability is not only about conception; it is also about the chance that a pregnancy continues. ACOG explains that as age increases, fertility decreases and risks such as miscarriage and chromosomal abnormalities increase. This is primarily related to the age-associated rise in chromosomal errors in eggs.

Miscarriage is common at all reproductive ages, and it is rarely caused by something the pregnant person did. However, the probability increases with maternal age, particularly after 35 and more substantially after 40. Chromosomal conditions, including trisomies, also become more common with age. This does not mean that a healthy pregnancy is unlikely or impossible after 35; many people have uncomplicated pregnancies and healthy babies in their late 30s and 40s. It does mean that preconception counseling and early prenatal care can be especially valuable.

If pregnancy occurs at an older reproductive age, clinicians may discuss options such as early ultrasound confirmation, screening for chromosomal conditions, diagnostic testing when appropriate, and monitoring for pregnancy-related conditions. These decisions are individualized and should be made with a qualified healthcare professional.

Cumulative probability: why time to pregnancy changes with age

Monthly probability compounds over time. If the chance of conception in one cycle is relatively high, many couples will conceive within several cycles. If the monthly probability is lower, it can take longer, and fewer couples will conceive within the same time frame.

This is one reason medical advice about when to seek help changes by age. For

people younger than 35 with regular cycles and no known fertility concerns, many clinicians suggest evaluation after 12 months of trying. For people aged 35 or older, evaluation is often recommended after 6 months. For people over 40, or those with irregular cycles, known endometriosis, prior pelvic infection, recurrent pregnancy loss, or a male partner with known sperm concerns, earlier consultation may be appropriate.

Seeking evaluation is not an admission of failure. It is a time-sensitive way to identify treatable factors such as ovulatory dysfunction, thyroid disease, hyperprolactinemia, tubal blockage, uterine cavity abnormalities, or impaired semen parameters. means that waiting too long can reduce the range of effective options.

Male age and couple-level probability

Female age has the strongest and most predictable effect on natural conception probability, but sperm-producing partners also contribute to fertility. With increasing male age, semen volume, motility, morphology, and DNA integrity may change. The effect is typically more gradual than ovarian aging, but it can still influence time to pregnancy, miscarriage risk, and assisted reproduction outcomes.

Couple-level fertility depends on the interaction between ovulation, egg quality, sperm quality, tubal function, uterine receptivity, intercourse timing, and general health. This is why both partners are usually included in a fertility assessment. A semen analysis is noninvasive and often provides important information early in evaluation.

Improving the odds within the limits of biology

No lifestyle change can reverse ovarian aging, but several evidence-informed steps can support the best possible chance within your biological context. The highest-yield behavioral factor is usually timing intercourse in the fertile window, especially the 5 days before ovulation and the day of ovulation. Intercourse every 1-2 days during this window is often sufficient for many couples.

Track cycles using menstrual dates, cervical mucus, ovulation predictor kits,

or clinician-guided methods if cycles are irregular.
Consider preconception care to review medications, chronic conditions, vaccinations, genetic carrier screening, and folic acid intake.
Avoid smoking and limit alcohol; smoking is associated with earlier ovarian aging and lower fertility.
Aim for sustainable nutrition, movement, and sleep habits that support metabolic and reproductive health.
Seek evaluation sooner if cycles are very irregular, periods are absent, pelvic pain is significant, or there is a history of endometriosis, pelvic surgery, sexually transmitted infection, chemotherapy, or recurrent miscarriage.

These steps may improve the conditions for conception, but they cannot guarantee pregnancy. It is reasonable to ask for help early, particularly if age is a concern.

IVF, egg freezing, and age-related probability

Assisted reproductive technology can help many people conceive, but it is also affected by age. IVF success using a person’s own eggs declines as egg quantity and egg quality decline. This is why age at egg retrieval is a major determinant of IVF outcomes. Donor eggs from younger donors can partly bypass egg-age effects, although pregnancy still requires individualized medical assessment.

Egg freezing, or oocyte cryopreservation, may be an option for people who want to preserve reproductive potential before fertility declines further. It is not a guarantee of a future baby, and success depends strongly on age at freezing, number of mature eggs stored, laboratory quality, and future health factors. A reproductive endocrinologist can explain realistic probabilities based on age and ovarian reserve testing.

If you are in your mid-30s or older and know you want children but are not ready to conceive, a fertility consultation can be informative even if you do not pursue treatment immediately. The goal is not to pressure you, but to provide a clearer picture of options and timelines.