

## Common mistakes when trying to get pregnant



### 1. Mistiming intercourse around ovulation

A frequent mistake is assuming that intercourse only on the day of ovulation is sufficient. Ovulation is important, but sperm can survive for several days in favorable cervical mucus, whereas the oocyte is viable for a much shorter period after release. The most fertile interval is typically the 2 to 3 days before ovulation and approximately 12 to 24 hours afterward. Waiting until ovulation has clearly occurred may therefore miss the highest-probability days.

Another mistake is having intercourse too infrequently. For many couples, intercourse every 1 to 2 days during the fertile window is a reasonable approach. Outside the fertile window, intercourse of days the risk of missing ovulation, especially in people with variable cycle length. Very rigid schedules may create stress and performance pressure, but prolonged abstinence can also be counterproductive for timing.

Common timing errors include:

Relying only on the calendar day of a cycle despite irregular or variable cycles.

Assuming ovulation always occurs on day 14; this is only a population average

for some 28-day cycles.

Having intercourse only after a basal body temperature rise, which usually confirms that ovulation has already occurred.

Using ovulation predictor kits but starting them too late in the cycle.

Stopping intercourse too soon after a positive ovulation test.

A pragmatic strategy is to identify the likely fertile window using several signals estimate. If cycles are regular, a calendar method can help approximate the window. If cycles vary, cervical mucus changes and urinary luteinizing hormone testing may provide more actionable information. consider seeking evaluation if cycles are persistently very short, very long, absent, or unpredictable, because cycle irregularity may reflect anovulation or endocrine disease.

## **2. Overtrusting apps, calendars, or a single fertility sign**

Cycle-tracking apps can be helpful, but many estimate ovulation using prior cycle length and population averages. That approach is less reliable in postpartum cycles, perimenopause, polycystic ovary syndrome, thyroid disease, hypothalamic dysfunction, after stopping hormonal contraception, and any situation with irregular bleeding. Treating an app prediction as a precise biologic measurement can lead to repeated mistiming.

Basal body temperature tracking is also often misunderstood. A sustained temperature rise usually reflects progesterone production after ovulation, so it is better for confirming that ovulation likely occurred than for predicting the most fertile days in real time. Measurements can be disrupted by alcohol, smoking, poor sleep, illness, shift work, travel, and activity before checking temperature. If these confounders are not considered, charts may be misleading.

Cervical mucus monitoring can be useful because estrogenic, fertile-type mucus often becomes clear, stretchy, and slippery before ovulation. However, infections, lubricants, semen, medications, dehydration, and individual variation can make interpretation difficult. Urinary ovulation predictor kits detect the LH surge, but they can be confusing in conditions associated with persistently elevated LH or multiple surges.

The symptothermal approach combines calendar tracking, cervical mucus

assessment, and basal body temperature rather than relying on a single sign. In practice, many couples use a blended strategy: estimate the likely fertile window from cycle length, begin ovulation testing before the expected surge, observe cervical mucus, and continue intercourse through the day after a positive test. If results are consistently unclear, a clinician can help determine whether ovulation is occurring and whether further evaluation is appropriate.

### **3. Waiting too long to seek medical evaluation**

Some couples for years before asking for help, often because they believe fertility treatment always means in vitro fertilization or because they eventually. In reality, an evaluation modifiable issues, confirm ovulation, assess ovarian reserve in context, evaluate the uterus and fallopian tubes when indicated, and analyze semen parameters. Not every evaluation leads to advanced treatment.

General guidance is to seek medical assessment after 12 months of regular unprotected intercourse if the person trying to conceive is under 35, or after 6 months if age 35 or older. Earlier consultation is reasonable for people with known or suspected reproductive risk factors.

Reasons not to delay evaluation include:

Age 35 or older, and especially age 40 or older.

Irregular, absent, or very painful periods.

Known endometriosis, fibroids affecting the uterine cavity, polycystic ovary syndrome, premature ovarian insufficiency, or prior ovarian surgery.

History of pelvic inflammatory disease, , tubal surgery, or sexually transmitted infections.

Recurrent pregnancy loss.

Known male-factor risks such as prior testicular surgery, chemotherapy, anabolic steroid use, erectile or ejaculatory dysfunction, or abnormal semen analysis.

Seeking help is not a failure. It is a time-sensitive medical decision.

Age-related changes in oocyte quantity and quality are clinically relevant, and some causes of infertility are not detectable from cycle tracking alone.

Couples should also avoid self-diagnosing based on home tests or social media content; interpretation requires clinical context.

#### **4. Ignoring weight, metabolic health, and extremes of exercise**

Body weight and risks, and response to fertility treatment. A body mass index in a healthy range is associated with better reproductive outcomes for many people, although BMI is an imperfect proxy and should not be used in isolation. WebMD notes that a BMI roughly between 18.5 and 27 is a reasonable target range for fertility optimization, but individual assessment is important, particularly for muscular individuals, people with eating disorders, or those with metabolic disease.

Both undernutrition and excess adiposity the hypothalamic-pituitary-gonadal axis. Low energy availability may suppress gonadotropin-releasing hormone pulsatility and impair ovulation. Insulin resistance and hyperandrogenism, as seen in many people with polycystic ovary syndrome, may also contribute to ovulatory dysfunction. In men, obesity is associated with and may be associated with lower semen quality in some studies.

Exercise is beneficial, but extremes can be problematic. Moderate physical activity supports cardiometabolic health and stress regulation. Excessive training, especially when combined with inadequate caloric intake, low body fat, or menstrual irregularity, may reduce ovulatory frequency. Conversely, sedentary behavior can worsen insulin resistance and weight-related risk factors.

Common errors include crash dieting, rapid weight loss, overtraining, using unregulated supplements, and focusing only on the female partner. A safer approach is gradual, sustainable improvement: adequate protein and micronutrients, balanced energy intake, regular moderate activity, sleep optimization, and management of conditions such as diabetes, thyroid disease, hypertension, and hyperprolactinemia with professional guidance.

#### **5. Smoking, vaping, alcohol, drugs, and excessive caffeine**

Tobacco exposure is one of the clearest preconception risks. Smoking can adversely affect ovarian reserve, tubal function, implantation, miscarriage

risk, sperm concentration, motility, morphology, and DNA integrity. Secondhand smoke also matters. Vaping is not a proven safe alternative when or during pregnancy; nicotine and other aerosol constituents may carry reproductive or fetal risks.

Heavy alcohol intake can impair fertility and is unsafe in pregnancy. Because early embryonic development occurs before many people know they are alcohol while is a cautious strategy. If alcohol use is heavy, daily, or difficult to stop, medical support is appropriate; abrupt cessation may require supervision in dependent individuals.

Recreational drugs, including cannabis, cocaine, opioids used nonmedically, methamphetamine, and anabolic-androgenic steroids, reproductive hormones, ovulation, sperm production, sexual function, and pregnancy outcomes. Anabolic steroid use in men is a particularly important and sometimes overlooked cause of suppressed spermatogenesis.

Caffeine does not usually need to be eliminated entirely, but excessive intake is a common mistake. WebMD advises moderation to under a few cups of coffee daily. Many clinicians use a conservative threshold similar to pregnancy guidance, often around 200 mg caffeine per day, but individual recommendations may vary. Remember that caffeine is also present in tea, energy drinks, cola, chocolate, and some medications.

The key point is not perfection; it is risk reduction before conception. Both partners should address tobacco, nicotine, high alcohol intake, recreational drugs, and excessive caffeine. If substance use is significant, clinicians can offer evidence-based cessation support and safer treatment planning.

## **6. Skipping prenatal vitamins, folic acid, vaccines, and preconception care**

A common misconception is that prenatal care starts after a positive pregnancy test. In fact, many critical developmental events occur in the first weeks after conception, before pregnancy is recognized. Preconception care is therefore an essential part of .

Folic acid is especially important because adequate folate status before conception and in early pregnancy reduces the risk of neural tube defects. Many

people take a prenatal vitamin containing folic acid or folate while , but dosing should be individualized for those with prior neural tube defect-affected pregnancy, certain antiseizure medications, malabsorption, or other higher-risk conditions.

Vaccine review is another often missed step. Immunity to rubella and varicella, influenza vaccination, COVID-19 vaccination when indicated, hepatitis B vaccination for at-risk individuals, and other immunizations may be relevant. Some vaccines are live attenuated and require timing considerations before pregnancy, so this should be reviewed with a clinician rather than handled casually.

Preconception care should also include:

Review of chronic diseases such as diabetes, hypertension, thyroid disease, kidney disease, autoimmune disease, epilepsy, depression, and asthma.

Medication and supplement review for teratogenicity, safety, and necessity.

Screening for sexually transmitted infections when indicated.

Discussion of genetic carrier screening based on personal, family, and ancestry-related factors.

Dental care, nutrition, sleep, occupational exposures, and environmental risks.

Skipping can lead to preventable risks. Importantly, patients should not stop prescribed medications abruptly when . The risk of untreated disease may exceed the risk of the medication. Medication changes should be made with the prescribing clinician and, when needed, a maternal-fetal medicine specialist or reproductive specialist.

## **7. Stopping or starting medications without professional guidance**

Another common mistake is making medication decisions based on fear rather than risk-benefit assessment. Some medications are contraindicated in pregnancy or require substitution before conception. Others are relatively safe and essential for maintaining health. Abruptly stopping treatment for epilepsy, hypertension, diabetes, thyroid disease, depression, bipolar disorder, inflammatory bowel disease, lupus, or anticoagulation-related conditions can create serious maternal and fetal risks.

Over-the-counter drugs and supplements also matter. Nonsteroidal anti-inflammatory drugs, isotretinoin, certain antihypertensives, some antiseizure drugs, warfarin, methotrexate, mycophenolate, and some acne, migraine, or weight-loss medications may require special planning. Herbal products and fertility supplements can have pharmacologic effects, contaminants, or interactions, and many are not supported by strong evidence.

A safe preconception medication review asks three questions: Is the medication necessary? Is it compatible with conception and pregnancy? If not, what is the safest transition plan and timing? These decisions should be individualized. Pharmacists, obstetricians, reproductive endocrinologists, primary care clinicians, psychiatrists, neurologists, endocrinologists, and maternal-fetal medicine specialists may all be relevant depending on the condition.

## **8. Treating fertility as only a female issue**

Fertility is a couple-level outcome. Male-factor infertility contributes to a substantial proportion of infertility cases, either alone or in combination with female factors. Yet many couples spend months tracking ovulation while never assessing semen parameters. A semen analysis is noninvasive, relatively accessible, and often informative.

Common male-side mistakes include smoking, heavy alcohol use, cannabis use, anabolic steroid or testosterone use, heat exposure to the testes, untreated varicocele when clinically relevant, poor sleep, obesity, and delaying evaluation for erectile or ejaculatory dysfunction. Testosterone therapy is especially important: exogenous testosterone can suppress pituitary gonadotropins and markedly reduce sperm production.

Men or sperm-producing partners should consider medical review if there is a history of undescended testes, testicular trauma, mumps orchitis, chemotherapy, radiation, pelvic surgery, hernia repair complications, genetic conditions, recurrent infections, or prior abnormal semen analysis. A reproductive urologist may be appropriate when semen parameters are abnormal or when potentially correctable male-factor issues are suspected.

Optimizing fertility works best when both partners participate. Shared changes in smoking cessation, nutrition, exercise, sleep, and substance reduction can

improve general health and may improve reproductive outcomes.

## **9. Using lubricants, timing habits, or post-intercourse rituals incorrectly**

Some couples overlook practical factors during intercourse. Certain lubricants can impair sperm motility in laboratory settings. If lubrication is needed, couples may prefer products labeled as fertility-friendly, though this should not be seen as a treatment for infertility. Avoid using saliva or oils as substitutes if sperm exposure is a concern, because they may not be sperm-compatible and can irritate tissues.

Post-intercourse rituals are another area of misinformation. There is no strong evidence that standing on one's head, prolonged bed rest, special positions, or elaborate timing rituals meaningfully improve conception rates. A brief period lying down is harmless if preferred, but the focus should remain on fertile-window timing and overall health rather than rituals.

On the other hand, intercourse should not become so regimented that it causes distress, erectile dysfunction, avoidance, or relationship strain.

Fertility-directed intercourse can create psychological pressure. Couples should communicate openly and seek support if attempts to conceive are affecting intimacy, mood, or functioning.

## **10. Following viral trends instead of evidence-based guidance**

Social media fertility advice often mixes plausible physiology with unsupported claims. Examples include extreme detoxes, seed cycling as a substitute for evaluation, unregulated hormone-balancing supplements, vaginal steaming, excessive restriction diets, and claims that a single food or position will overcome infertility. These approaches can delay diagnosis, waste money, create guilt, or cause harm.

Evidence-based preconception care is usually less sensational: identify the fertile window, have appropriately timed intercourse, take folic acid or a prenatal vitamin, review medications and vaccines, avoid tobacco and recreational drugs, moderate caffeine, optimize chronic conditions, and seek evaluation on time. If fertility treatment is needed, options range from ovulation induction and intrauterine insemination to IVF, depending on

diagnosis and goals.

Patients should be cautious with any advice that promises guaranteed pregnancy, discourages medical evaluation, recommends stopping prescribed medications, sells expensive proprietary protocols, or blames infertility entirely on willpower or lifestyle. Infertility is a medical condition, not a character flaw.