How age affects chances of getting pregnant

The basic pattern: fertility declines with age, especially after 35

Fertility is not a switch that turns off at a single birthday. It is a gradual biological process with wide individual variation. However, population-level data show a consistent pattern: the is generally highest in the late teens and 20s, starts to decline around age 30, and declines more rapidly after age 35. By the early 40s, natural conception is still possible for some people, but the is much lower.

One government health resource estimates that women in their early to mid-20s have about a 25% to 30% in a given menstrual cycle if they are having regular unprotected intercourse. This monthly chance declines slowly in the early 30s, then more rapidly after 35, reaching roughly 5% per cycle by age 40. A scientific review similarly reports that the probability of conceiving within one year is approximately 85% for women under 30, 75% at age 30, 66% at age 35, and 44% at age 40.

These figures are averages, not predictions for any one person. A 38-year-old may conceive quickly, while a 28-year-old may need evaluation for ovulatory, tubal, uterine, sperm, endocrine, or other factors. Age is powerful, but it is never the whole story.

Why age affects fertility: ovarian reserve and egg quality

People with ovaries are born with a finite pool of oocytes. Over time, the number of remaining follicles declines through atresia and ovulation. This is often described as a reduction in ovarian reserve, meaning the quantity of eggs available for recruitment and ovulation is decreasing. Tests such as anti-Mˆ…llerian hormone, antral follicle count, and follicle-stimulating hormone may help clinicians estimate ovarian reserve, but they do not perfectly predict whether a person will conceive naturally in a given month.

Egg quality is equally important. As age increases, a larger proportion of oocytes have chromosomal abnormalities, particularly errors in chromosome separation during meiosis. These aneuploid embryos are less likely to implant, more likely to miscarry, and, in some cases, may lead to chromosomal conditions. This is why fertility decline after the mid-30s is not only about having fewer eggs; it is also about the decreasing probability that any given egg will produce a chromosomally typical embryo capable of ongoing development.

This biology can feel unfair, especially for people who are healthy, active, and menstruating regularly. Regular periods can indicate ongoing ovulation, but they do not necessarily mean fertility is the same as it was earlier in life. Menstruation may continue for years while egg quantity and quality are declining.

Age and time to pregnancy

refers to how long it takes to unprotected around the fertile window. Because conception is probabilistic, even couples with no infertility factors may take several months to . Age changes those odds.

In younger reproductive years, the probability per cycle is higher, is more likely to occur within the first several months of trying. In the mid-to-late 30s and early 40s, each individual cycle has a of success, so the cumulative chance over six or twelve months falls. This is one reason clinical guidance often recommends earlier fertility evaluation for people aged 35 or older.

General medical guidance commonly suggests seeking evaluation after 12 months

of trying if under 35, after 6 months if 35 or older, and sooner if there are known concerns such as irregular or absent periods, endometriosis, prior pelvic infection, recurrent miscarriage, known sperm issues, chemotherapy exposure, or a history of ovarian, tubal, or uterine surgery. These timelines are not meant to pressure anyone; they exist because time is a clinically relevant factor when ovarian reserve is declining.

Miscarriage and chromosomal risks increase with age

Age also affects what happens after conception. Miscarriage is common at all reproductive ages and is often caused by chromosomal abnormalities that occur by chance. As oocyte age increases, the risk of embryonic aneuploidy rises, which contributes to a higher miscarriage rate.

A review cited in the source material reports miscarriage rates of about 16% in women under 30 and about 27% at age 40. These numbers can be painful to read, particularly for anyone who has experienced pregnancy loss. It is important to emphasize that miscarriage is usually not caused by something the pregnant person did or did not do. If losses are recurrent, medical evaluation may identify treatable factors in some cases, but sometimes no clear cause is found.

Chromosomal conditions also become more common with increasing maternal age. This does not mean that most pregnancies at older ages are affected, but the risk is higher than at younger ages. Prenatal screening and diagnostic testing options can help estimate or confirm certain chromosomal findings. Decisions about screening, diagnostic testing, and pregnancy management are personal and should be made with an obstetric clinician, genetic counselor, or maternal-fetal medicine specialist as appropriate.

Pregnancy after 35: possible, common, but medically different

Many people have healthy pregnancies and healthy babies after age 35. The term historically used in obstetrics, advanced maternal age, generally refers to pregnancy with an expected delivery at age 35 or older. The term can sound alarming, but it is primarily a clinical risk category used to guide counseling, screening, and monitoring.

According to ACOG, fertility peaks from the late teens through the late 20s,

begins declining by age 30, and declines faster in the mid-30s. ACOG also notes that natural pregnancy is unlikely for most people by age 45 because of reduced egg number and egg quality. Pregnancy at older ages may carry higher risks of miscarriage, stillbirth, multiple pregnancy, and chromosomal abnormalities. Other complications, such as gestational diabetes, hypertensive disorders of pregnancy, placenta-related problems, cesarean birth, and preterm birth, may also become more common with age, often interacting with baseline health conditions.

Preconception care is particularly valuable for people planning pregnancy in their mid-30s or later. This may include reviewing medications for pregnancy safety, optimizing chronic conditions such as hypertension, diabetes, thyroid disease, autoimmune disease, or epilepsy, discussing folic acid, checking immunization status, and considering genetic carrier screening. The goal is not to medicalize every later-life pregnancy, but to reduce modifiable risks before conception whenever possible.

Male age matters too

Fertility conversations often focus on maternal age, but paternal age can also influence reproductive outcomes. Sperm production continues throughout life, yet semen parameters, sperm DNA integrity, sexual function, and overall health can change with age. The decline is typically more gradual than ovarian aging, but it can still be clinically meaningful.

The Better Health Channel notes that male fertility over age 45 can prolong the time it takes to conceive and may be associated with increased risks. Advanced paternal age has been studied in relation to miscarriage, some pregnancy complications, and certain neurodevelopmental or genetic outcomes, although absolute risks for many outcomes remain low and are influenced by multiple factors.

For couples or partners , it is reasonable to evaluate both partners rather than assuming age-related difficulty is solely ovarian. Semen analysis is noninvasive and often part of an initial fertility assessment. Lifestyle factors such as smoking, heavy alcohol use, anabolic steroid use, heat exposure to the testes, obesity, untreated sleep apnea, and some medications may also affect sperm health and are worth discussing with a clinician.

Assisted reproduction and age: helpful, but not a guarantee

Assisted reproductive technologies, including ovulation induction, intrauterine insemination, and in vitro fertilization, can help . However, age remains a major determinant of success, especially when using one's own eggs. IVF can improve the efficiency of bringing eggs and sperm together and selecting embryos for transfer, but fully reverse age-related egg quality decline.

Some people consider fertility preservation, such as egg or embryo freezing, before they are ready to attempt pregnancy. Freezing eggs at a younger age generally preserves eggs at the age they were retrieved, which may improve future options. Still, egg freezing does not guarantee a baby, and outcomes depend on age at freezing, number of mature eggs stored, lab quality, sperm factors if embryos are made, uterine health, and future medical circumstances.

For some individuals or couples, donor eggs, donor sperm, donor embryos, gestational carriers, or adoption may become part of family-building discussions. These are deeply personal choices involving medical, emotional, ethical, legal, cultural, and financial considerations. A reproductive endocrinologist and infertility specialist can explain realistic probabilities and options based on an individual's history.

Practical planning without panic

Understanding age-related fertility can support thoughtful planning, but it should not become a source of constant fear. If you know you want children, age can be one factor in deciding , whether to seek preconception counseling, or whether to explore fertility preservation. If you are unsure, a consultation can still be useful; you do not need to have every life decision finalized before asking questions.

Helpful steps to discuss with a healthcare professional may include:

Reviewing menstrual regularity, prior pregnancies, pelvic surgeries, infections, endometriosis symptoms, and family history of early menopause. Assessing general changes, nutrition, exercise, sleep, and substance exposure. Considering ovarian reserve testing when appropriate, while understanding its

limitations.
Evaluating sperm health if there is a male partner or sperm source.
Discussing timing for fertility evaluation based on age and known risk factors.

Most importantly, fertility statistics describe groups, not destinies. They can guide decisions, but they cannot define your worth, your future, or the legitimacy of your hopes. If the , you are not alone; support from clinicians, counselors, partners, peers, or fertility support groups can make the process less isolating.