Trying for 3 months without success

Three months is usually still within the normal range

If you have been trying for three months without success, it is understandable to wonder whether something is wrong. In clinical terms, however, three months is usually too early to label the situation as infertility. Human reproduction is efficient, but not perfectly efficient. Even with ovulation, sperm exposure in the fertile window, open fallopian tubes, and a receptive uterine environment, conception may not occur in a given cycle.

Medical definitions use longer time frames because month-to-month fecundability, meaning the probability of conception in one menstrual cycle, is limited. Scientific literature recognizes that conception is often most likely early in the period of trying, but also that many couples who do not conceive immediately will still conceive later without treatment. Subfertility is commonly defined in research as failure to conceive after one year of regular unprotected intercourse, although some health systems use slightly different thresholds for formal diagnosis or referral.

This matters emotionally. A negative test after three cycles can feel like evidence, but medically it is often still a small sample size. It may reflect normal probability rather than a specific disorder. That does not make the

disappointment less real. It simply means that the absence of pregnancy after three months should usually be interpreted with caution, not panic.

Check fertile window timing without over-monitoring

One of the most practical things to review at the three-month point is fertile window timing. The fertile window includes the days leading up to ovulation and the day of ovulation itself. Sperm can survive for several days in fertile cervical mucus, while the egg is viable for a shorter period after ovulation. Intercourse every two to three days across the cycle, or every one to two days during the fertile window, is often enough for many couples.

Ovulation predictor kits, cervical mucus observations, basal body temperature charts, and cycle-tracking apps can all provide clues, but each has limitations. Ovulation predictor kits detect the luteinizing hormone surge, which usually precedes ovulation, but a positive result does not guarantee egg release in every situation. Basal body temperature confirms a post-ovulatory temperature shift, but it identifies ovulation retrospectively. Apps estimate timing from past cycle patterns and may be inaccurate if cycles vary.

If tracking is increasing anxiety or making sex feel clinical, consider simplifying. For people with cycles around 24 to 35 days, regular intercourse every two to three days often covers the fertile period without daily testing. If cycles are very irregular, absent, or consistently longer than about 35 days, the issue may be less about timing and more about ovulatory dysfunction, which is a reason to ask a healthcare professional for advice earlier.

Factors that can affect conception in the first few months

Conception requires several steps to align: ovulation, sperm production and transport, cervical mucus support, fertilization, tubal transport, embryo development, implantation, and early hormonal support. A delay at three months does not identify which step, if any, is affected. Still, it is useful to understand the main categories clinicians think about.

Ovulatory factors: Irregular or absent periods, polycystic ovary syndrome, thyroid disease, hyperprolactinemia, low energy availability, and some medications can affect ovulation.

Male-factor contributors: Sperm concentration, motility, morphology, ejaculation difficulties, prior testicular injury, anabolic steroid use, heat exposure, and some medical treatments can reduce the chance of fertilization.
Tubal and pelvic factors: Prior pelvic inflammatory disease, ectopic pregnancy, pelvic surgery, endometriosis, or known tubal disease can interfere with egg and sperm meeting.
Uterine factors: Fibroids that distort the uterine cavity, intrauterine adhesions, or congenital uterine differences may affect implantation in some cases.
Age-related factors: Egg quantity and quality decline with age, and the timing for seeking evaluation becomes shorter as age increases.

None of these can be diagnosed from three negative cycles alone. But if you already know you have one of these risk factors, it is reasonable to discuss your personal timeline with a clinician instead of waiting passively.

When to seek medical advice sooner

For many people under 35 with regular cycles and no known risk factors, professional organizations commonly recommend an infertility evaluation after 12 months of regular unprotected intercourse. ACOG recommends evaluation after one year, or after six months if the person trying to conceive is older than 35. The NHS advises contacting a GP after one year of trying, or sooner if there are known factors that could affect fertility. Some systems define infertility after a longer duration, but medical advice can still be appropriate before a formal diagnosis is made.

At three months, earlier review is sensible if you have absent periods, very irregular cycles, severe pelvic pain, suspected endometriosis, a history of pelvic infection, previous ectopic pregnancy, known tubal disease, repeated pregnancy loss, chemotherapy or pelvic radiation history, or a partner with known sperm or ejaculation concerns. It is also reasonable if you need medication review because some drugs are unsafe in pregnancy or may affect ovulation.

The age 35 fertility timeline is important because reproductive aging changes the balance between reassurance and investigation. This does not mean pregnancy after 35 is impossible; many people conceive and have healthy pregnancies. It

means clinicians often avoid waiting a full year before checking for treatable barriers. If you are 35 or older, or close to that age and worried, a preconception appointment can help personalize the plan.

What a preconception health review may cover

A preconception health review is not the same as an infertility workup. It is a preventive visit focused on optimizing health before pregnancy and identifying issues that deserve earlier attention. It may include menstrual history, pregnancy history, medical conditions, medications, vaccinations, lifestyle factors, occupational exposures, and family or genetic history. The clinician may discuss folic acid, weight changes if medically relevant, smoking or vaping cessation, alcohol, recreational drugs, sleep, and chronic disease control.

Depending on your history, basic blood tests may be considered, such as thyroid function, hemoglobin or iron status, rubella immunity, varicella immunity, or diabetes screening. These are not universally required for everyone at three months, and recommendations vary by country and individual risk. If cycles suggest inconsistent ovulation, a clinician may discuss targeted hormone testing rather than broad, non-specific panels.

A full infertility evaluation after 12 months, or after six months in some age groups or risk situations, is more structured. It often considers ovulation assessment, tubal patency testing, uterine cavity evaluation, and semen analysis in fertility assessment. Importantly, male-factor infertility can occur without obvious symptoms, so evaluation should not focus only on the person who will carry the pregnancy. If testing becomes appropriate later, both partners are usually part of the assessment.

Managing the emotional weight of each cycle

Three months can be emotionally intense because each cycle contains a miniature arc of hope, vigilance, uncertainty, and grief. You may notice every twinge, compare yourself with friends, or feel betrayed by your body when your period arrives. These reactions are common. They do not mean you are overreacting.

It can help to create boundaries around trying. Some people choose specific days for ovulation testing and avoid repeated pregnancy tests before the

expected period. Others stop using apps for a cycle and return to a simpler intercourse pattern. If sex has become purely goal-directed, protecting intimacy may matter as much as optimizing timing. Emotional exhaustion can reduce quality of life even when there is no medical problem.

Consider deciding in advance what you will do if the next cycle is negative: perhaps continue trying for a defined period, book a preconception visit, review cycle data, or take a tracking break. Having a plan can reduce the sense that every period is a crisis. If sadness, anxiety, relationship strain, or obsessive testing becomes hard to manage, support from a counselor, fertility-informed therapist, or trusted clinician can be appropriate even before any diagnosis exists.