Trying for 6 months without success

What six months without pregnancy can mean

Reaching the six-month point often brings a sharp shift in how trying to conceive feels. The first few cycles may have felt hopeful or experimental; by month six, many people start asking whether they have missed something. Medically, however, conception is probabilistic. Even with well-timed intercourse, ovulation, open fallopian tubes, and sperm capable of fertilization, pregnancy is not guaranteed in any single cycle.

Public health and clinical guidance generally define infertility as not becoming pregnant after 12 months of regular unprotected sex for many couples, with earlier evaluation often recommended when the female partner or person trying to conceive is 35 or older. This distinction matters because six months can be normal for some people and clinically relevant for others.

It may help to think of this point as a review point rather than a verdict. A careful look at cycle patterns, ovulation timing, intercourse frequency, medical history, medications, prior pelvic infections, surgeries, miscarriages, and partner factors can clarify whether continuing to try is reasonable or whether medical input should happen sooner.

When to seek help sooner rather than later

Age is one of the clearest reasons not to wait a full year. If the person trying to conceive is 35 or older, many medical organizations advise asking about fertility evaluation after 6 months of regular unprotected intercourse. This is not because pregnancy cannot happen naturally after 35; many people do conceive. The reason is that ovarian reserve and egg quality tend to decline with age, so time becomes a more important clinical factor.

Earlier assessment is also sensible if cycles are very irregular, absent, or consistently shorter than about 21 days or longer than about 35 days, because these patterns may suggest ovulatory dysfunction. Other reasons to seek care earlier include known endometriosis, previous pelvic inflammatory disease, prior ectopic pregnancy, a history of pelvic or testicular surgery, chemotherapy or radiation exposure, recurrent pregnancy loss, or a known semen abnormality.

You do not need to prove that something is wrong before making an appointment. A preconception or fertility visit can be informational: reviewing medications, confirming immunizations, discussing folic acid, checking thyroid or other relevant conditions when indicated, and deciding whether a structured workup is appropriate.

Timing, ovulation, and the fertile window

Before assuming a medical problem, it is worth checking whether intercourse is landing in the fertile window. Pregnancy is most likely from intercourse in the several days before ovulation and on the day of ovulation. Because sperm can survive for several days in the reproductive tract, intercourse every 1 to 2 days during the fertile window is often more practical than trying to identify one perfect day.

Ovulation predictor kits can be useful because they detect the luteinizing hormone surge that usually precedes ovulation. However, positive ovulation tests without pregnancy do not prove that everything else is normal. They suggest a hormonal signal occurred, but they do not confirm egg release with certainty, tubal patency, fertilization, embryo development, or implantation.

Cycle tracking apps can estimate fertile days, but their predictions may be inaccurate if cycles vary. Cervical mucus changes, basal body temperature patterns, and ovulation tests can add information, though they can also increase stress. If tracking is making sex feel clinical or emotionally draining, it may be reasonable to simplify: regular intercourse two to three times weekly often covers the fertile window for people with moderately regular cycles.

Common medical factors doctors consider

Fertility depends on several steps working together: ovulation, sperm production and function, transport through the cervix and uterus, open fallopian tubes, fertilization, embryo development, and implantation in a receptive uterine environment. A delay can arise from one factor, several mild factors together, or no clearly identifiable cause after testing.

Ovulation problems and infertility are closely linked. Conditions such as polycystic ovary syndrome, thyroid disease, elevated prolactin, significant weight change, intense exercise, or perimenopausal ovarian changes may affect ovulation. Tubal factors may follow pelvic infection, endometriosis, or prior abdominal or pelvic surgery. Uterine factors, including fibroids that distort the cavity, polyps, adhesions, or congenital uterine differences, may also be considered depending on symptoms and history.

Male-factor infertility is common and may have no obvious symptoms. Semen quality involves sperm concentration, movement, shape, volume, and sometimes additional functional issues. Because semen analysis is relatively accessible and noninvasive, many clinicians include it early rather than waiting until extensive testing has been done for the female partner or person carrying the pregnancy.

What a fertility assessment may involve

A fertility assessment after six months is usually tailored to age, history, and symptoms. It may begin with a detailed history from both partners, including cycle length, pregnancy history, sexual timing, medical conditions, surgeries, medications, smoking, alcohol or drug exposure, occupational exposures, and family history. Clinicians may also ask about pain with periods

or sex, heavy bleeding, acne or excess hair growth, prior sexually transmitted infections, or erectile and ejaculation concerns.

Testing, when appropriate, may include confirmation of ovulation, ovarian reserve markers, thyroid or prolactin testing, pelvic ultrasound, assessment of the uterine cavity, and fallopian tube patency testing. A semen analysis during fertility evaluation can provide important information early. Not everyone needs every test immediately, and results should be interpreted in context by a qualified clinician.

Sometimes all initial results are reassuring. This can be both comforting and frustrating. The term unexplained infertility after normal tests does not mean the problem is imaginary; it means standard testing has not identified the limiting step. Your clinician can discuss whether continued trying, additional testing, ovulation-related treatment, intrauterine insemination, or referral to a reproductive endocrinologist is appropriate.

Caring for your body while you keep trying

There are supportive steps that are generally reasonable while you decide whether to seek care. Taking a prenatal vitamin with folic acid before conception helps reduce the risk of neural tube defects. If you smoke, stopping is one of the most important fertility and pregnancy health steps you can take; smoking is associated with reduced fertility and pregnancy risks. Limiting alcohol, avoiding recreational drugs, and discussing medication safety with a healthcare professional are also sensible.

Weight, nutrition, sleep, and chronic disease management can influence reproductive health, but they should be approached without blame. People in many body sizes conceive, and fertility struggles are not a moral failure. If you have diabetes, thyroid disease, hypertension, autoimmune disease, epilepsy, depression, or another ongoing condition, a preconception visit can help optimize treatment before pregnancy.

Try to protect your relationship and mental health, too. Six months of negative tests can create grief, envy, performance pressure, and isolation. Consider setting limits on testing, deciding how much tracking you actually want, and agreeing with your partner about when to seek help. Asking for care is not

giving up on natural conception; it is gathering information.

How to think about the next few months

If you are under 35, have regular cycles, no major reproductive history concerns, and have only recently optimized timing, your clinician may reassure you that continuing until 12 months is reasonable. If you are 35 or older, have irregular cycles, known reproductive conditions, or a partner with possible semen concerns, the six-month mark is a good reason to book an appointment rather than waiting.

It can be useful to prepare a concise summary before the visit: how long you have been trying, cycle lengths, ovulation test results if used, frequency of intercourse, prior pregnancies or losses, surgeries, infections, medications, and any symptoms such as pelvic pain or heavy bleeding. Bringing both partners into the conversation can prevent the workup from focusing on only one side of reproduction.

Most importantly, try not to interpret the six-month mark as a personal failure. Pregnancy chances after 6 months vary by age, health history, intercourse timing, and chance. Fertility assessment after six months can be a practical, compassionate step when indicated, and continuing to try can also be medically reasonable for many people. The best next step is the one that fits your age, history, symptoms, and emotional bandwidth.