When to worry about not getting pregnant and what is normal

The normal range: conception often takes time

It is common to assume that if intercourse is unprotected and well timed, pregnancy should happen quickly. Biologically, conception requires several events to align: ovulation, viable sperm, open fallopian tubes, fertilization, embryo development, implantation, and adequate hormonal support. A small disruption in timing or biology can make a cycle end without pregnancy, even in healthy couples.

Because the probability of conception in any single cycle is limited, several months of trying can be normal. A negative pregnancy test after one, two, or three cycles does not automatically imply infertility. Many people who ultimately conceive naturally experience a period of repeated negative tests first.

The term infertility has a specific clinical use. According to the CDC, infertility is generally defined as not being able to get pregnant after 1 year of unprotected sex. This definition is a threshold for evaluation and public health measurement; it is not a judgment about a person’s body or a prediction that pregnancy cannot happen.

When to seek evaluation if you are under 35

If the woman or person with ovaries is younger than 35, has regular menstrual cycles, and there are no known fertility risk factors, many guidelines recommend trying for 12 months before starting an infertility evaluation. This does not mean you must ignore concerns during that year. It means that, statistically and medically, taking up to a year can still fall within the expected range.

Regular cycles often suggest that ovulation is occurring, although they do not prove it perfectly. For someone under 35 with cycles that are predictable and no history of reproductive disease, the first step is often optimizing timing and frequency of intercourse rather than rushing immediately to testing.

Practical steps during this period may include understanding the fertile window, avoiding tobacco and excessive alcohol, beginning a prenatal vitamin with folic acid as advised by a clinician, reviewing medications for pregnancy safety, and seeking preconception care if there are chronic medical conditions such as diabetes, thyroid disease, epilepsy, hypertension, autoimmune disease, or psychiatric conditions requiring medication.

When to seek evaluation if you are 35 or older

Age changes the timeline. The CDC and Mayo Clinic both note that people aged 35 or older should generally seek evaluation after 6 months of trying without pregnancy. This shorter timeframe reflects the age-related decline in ovarian reserve and oocyte quality, as well as the increased clinical value of identifying treatable factors sooner.

If you are over 40, many clinicians recommend seeking medical guidance even earlier, sometimes before trying or soon after beginning, especially if you want to understand ovarian reserve, pregnancy risks, miscarriage risk, and options for fertility support. This is not meant to create panic. It is meant to avoid losing time when time is a biologically relevant factor.

Age also matters for male partners, although the effect is usually more gradual. Semen parameters, DNA fragmentation, and reproductive outcomes can be influenced by age, illness, medications, heat exposure, anabolic steroid use,

and lifestyle factors. A couple-based evaluation is often more efficient than focusing only on the person who will carry the pregnancy.

Red flags that should not wait 6 to 12 months

Some symptoms and medical histories justify earlier assessment, regardless of how long you have been trying. These do not necessarily mean pregnancy is impossible, but they can signal conditions that may reduce fertility or increase the chance of pregnancy loss.

Irregular or absent periods: Cycles that are very unpredictable, frequently longer than 35 days, absent for months, or very short may indicate inconsistent ovulation or endocrine conditions.
Very painful periods: Severe dysmenorrhea, pain with intercourse, or chronic pelvic pain can be associated with endometriosis or other pelvic pathology.
Known or suspected endometriosis: Endometriosis can affect pelvic anatomy, inflammation, ovarian reserve, and tubal function.
History of pelvic inflammatory disease: Prior infection involving the uterus, fallopian tubes, or ovaries can increase the risk of tubal scarring.
Repeated miscarriage: Recurrent pregnancy loss warrants medical evaluation even if conception is occurring.
Prior cancer treatment: Chemotherapy, pelvic radiation, and some surgeries can affect ovarian, uterine, testicular, or hormonal function.
Known male-factor concerns: Prior abnormal semen analysis, testicular surgery, undescended testes, varicocele, erectile or ejaculatory dysfunction, or testosterone/anabolic steroid use can justify early testing.

If any of these apply, it is reasonable to contact an obstetrician-gynecologist, reproductive endocrinologist, urologist specializing in male fertility, or primary care clinician before the standard waiting period ends.

Cycle regularity, ovulation, and timing intercourse

One of the most common reasons pregnancy does not occur quickly is mistiming intercourse relative to ovulation. The fertile window is limited because an egg is viable for a relatively short time after ovulation, while sperm can survive for several days in fertile cervical mucus. Intercourse in the days leading up

to ovulation is often more effective than intercourse only after ovulation has already passed.

Regular cycles can make timing easier, but they do not guarantee that every cycle is ovulatory or that ovulation happens on the same day each month. Irregular cycles can make prediction more difficult and may reflect inconsistent ovulation. Ovulation predictor kits, cervical mucus observation, and cycle tracking can help some people, but tracking can also become stressful. The goal is useful information, not perfection.

For many couples, intercourse every 1 to 2 days during the fertile window or every 2 to 3 days throughout the cycle is a practical approach. If intercourse is painful, logistically difficult, or emotionally strained, that is also worth discussing with a clinician. Sexual pain, vaginismus, erectile dysfunction, ejaculatory concerns, and low libido are medical and relational issues that deserve supportive care, not shame.

What an initial fertility evaluation may involve

A fertility evaluation is not a single test. It is usually a structured assessment of ovulation, ovarian reserve, uterine anatomy, tubal patency, semen parameters, medical history, medications, and lifestyle factors. The exact workup depends on age, cycle pattern, prior pregnancies, symptoms, and how long you have been trying.

Common components may include a detailed menstrual and reproductive history, review of prior infections or surgeries, thyroid or prolactin testing when indicated, ovulation assessment, ovarian reserve markers such as anti-Mˆ…llerian hormone or antral follicle count, pelvic ultrasound, and tests to assess whether the fallopian tubes appear open. For the male partner, semen analysis is often an early, high-yield test because male-factor infertility contributes to a substantial proportion of cases.

Results can be reassuring, identify a specific issue, or be inconclusive. Some couples receive a diagnosis such as ovulatory dysfunction, tubal factor, endometriosis-associated infertility, uterine cavity abnormality, diminished ovarian reserve, or male-factor infertility. Others are told they have unexplained infertility, meaning standard testing has not found a clear cause.

In all situations, a clinician can help interpret what the findings mean and what options are reasonable.

What is worth doing before you reach the evaluation threshold

While waiting can be normal, passive waiting is not the only option. Preconception care can improve safety and sometimes identify issues before they affect fertility or pregnancy. A clinician can review immunizations, chronic conditions, medications, occupational exposures, genetic carrier screening options, and nutritional needs.

It is also reasonable to focus on modifiable factors without turning conception into a full-time project. Smoking cessation, avoiding recreational drugs, limiting alcohol, aiming for a sustainable weight range, managing sleep, and treating medical conditions can support reproductive health. People taking testosterone, isotretinoin, some anti-seizure medications, methotrexate, certain psychiatric medications, or other potentially pregnancy-relevant drugs should speak with a clinician before making changes.

Importantly, lifestyle changes are not a substitute for medical evaluation when red flags are present. They also should not be framed as blame. Fertility is complex, and many people with excellent health habits still need time or assistance to conceive.

The emotional side of waiting

Trying to conceive can become psychologically exhausting because it repeats in cycles: hope, timing, waiting, testing, and grief. The uncertainty can feel especially isolating when friends or relatives announce pregnancies easily. Feeling sad, jealous, angry, numb, or anxious does not mean you are ungrateful or weak; it means this matters deeply.

Consider setting boundaries around pregnancy announcements, social media, and unsolicited advice. Some couples choose a specific point in the cycle to talk about logistics and another time to talk about feelings, so fertility does not consume every conversation. Support groups, therapy, and fertility-focused counseling can be valuable, particularly after pregnancy loss, prolonged trying, or invasive treatment.

If trying to conceive is affecting sleep, appetite, work, relationships, or mental health, it is appropriate to seek professional support. Emotional distress is not a secondary issue; it is part of reproductive care.