Why you are not getting pregnant: main causes and hidden reasons

First: it may simply be taking time

Human reproduction is not perfectly efficient. Even in healthy couples with regular intercourse during the fertile window, pregnancy is not guaranteed in any single cycle. Ovulation must release a mature egg, sperm must be present in adequate number and function, fertilization must occur, the embryo must develop normally, and implantation must succeed. A missed pregnancy in one or several cycles can happen without implying infertility.

That said, time matters. If you are under 35 and have been trying for 12 months, or 35 or older and trying for 6 months, professional evaluation is recommended. Earlier care is appropriate if periods are very irregular or absent, if there is known pelvic inflammatory disease, endometriosis, chemotherapy exposure, recurrent pregnancy loss, or previous surgery involving the ovaries, fallopian tubes, uterus, or testes.

Ovulation problems: when eggs are not released regularly

Ovulatory dysfunction is one of the most common reasons pregnancy does not occur. If ovulation is infrequent, unpredictable, or absent, the number of opportunities for conception drops sharply. Clues may include cycles shorter

than about 21 days, longer than about 35 days, skipped periods, very heavy or very light bleeding, acne or excess facial hair, galactorrhea, or symptoms of thyroid imbalance.

Common ovulation-related causes include polycystic ovary syndrome, hypothalamic dysfunction related to stress, undernutrition, excessive exercise, or significant weight change, thyroid disease, hyperprolactinemia, and primary ovarian insufficiency. In some people, periods appear fairly regular but ovulation is inconsistent or luteal hormone patterns are suboptimal.

A clinician may evaluate ovulation with menstrual history, mid-luteal progesterone testing when appropriate, ultrasound monitoring, and hormone tests such as thyroid-stimulating hormone, prolactin, follicle-stimulating hormone, luteinizing hormone, estradiol, and anti-Mˆ…llerian hormone. These tests do not diagnose fertility potential on their own, but they can help guide next steps.

Age and ovarian reserve: egg quantity and quality change over time

Age is one of the strongest predictors of female fertility. Ovarian reserve refers broadly to the remaining number of eggs, but pregnancy potential also depends heavily on egg quality. As age increases, especially after the mid-30s and more rapidly after 40, the proportion of eggs with chromosomal abnormalities rises. This can reduce conception rates and increase the chance of early miscarriage.

Diminished ovarian reserve can also occur earlier than expected. Possible contributors include genetics, ovarian surgery, endometriosis, autoimmune conditions, smoking, chemotherapy, radiation, or sometimes no identifiable reason. Anti-Mˆ…llerian hormone and antral follicle count can provide information about likely ovarian response to fertility treatment, but they do not perfectly predict whether a person can conceive naturally.

This topic can feel painful because age is not something anyone can modify retroactively. The practical point is not blame; it is timing. If age may be a factor, seeking evaluation sooner can preserve more options.

Fallopian tube damage or blockage

For natural conception, at least one fallopian tube usually needs to be open and functional. The tube is not just a passive tunnel; it helps capture the ovulated egg, supports fertilization, and moves the early embryo toward the uterus. If tubes are blocked, scarred, or distorted, egg and sperm may not meet, or an embryo may implant outside the uterus, causing an ectopic pregnancy.

Risk factors for tubal disease include previous pelvic inflammatory disease, chlamydia or gonorrhea infection, endometriosis, ruptured appendix, prior ectopic pregnancy, pelvic or abdominal surgery, and adhesions from inflammation. Some people have no obvious history and only discover tubal factors during fertility testing.

Assessment may include hysterosalpingography, saline infusion sonography with contrast, or laparoscopy in selected cases. Because tubal disease can affect both fertility and pregnancy safety, it deserves medical evaluation rather than guesswork.

Endometriosis: inflammation, anatomy, and egg environment

Endometriosis occurs when tissue similar to the uterine lining grows outside the uterus. It may cause painful periods, pelvic pain, pain with intercourse, bowel or bladder symptoms around menstruation, or infertility. However, some people with endometriosis have few symptoms, making it a hidden reason for difficulty conceiving.

Endometriosis can impair fertility through multiple mechanisms: pelvic adhesions that distort the ovaries or tubes, ovarian endometriomas that affect ovarian tissue, chronic inflammation, altered immune signaling, and changes in egg, sperm, or embryo environment. Mild endometriosis may be difficult to detect without specialized evaluation.

Treatment decisions depend on age, pain symptoms, ovarian reserve, severity of disease, prior surgery, and how long you have been trying. A reproductive endocrinologist or gynecologist can help weigh observation, surgery, ovulation induction, intrauterine insemination, or in vitro fertilization where appropriate.

Uterine and cervical factors

Even if ovulation, sperm function, and fallopian tubes are adequate, implantation requires a receptive uterine cavity. Conditions that can interfere include submucosal fibroids, endometrial polyps, intrauterine adhesions, congenital uterine anomalies such as septate uterus, and chronic endometritis. These may be associated with heavy bleeding, spotting, recurrent miscarriage, pelvic pain, or no symptoms at all.

Fibroids are common, but not all fibroids reduce fertility. Location matters: fibroids that distort the uterine cavity are more likely to affect implantation or pregnancy maintenance than small fibroids located entirely within the outer uterine wall. Polyps can also be incidental or clinically relevant depending on size, number, and symptoms.

Cervical factors are less common than many people fear, but prior cervical surgery, cervical stenosis, or hostile mucus patterns may sometimes contribute. Evaluation may include pelvic ultrasound, saline sonography, hysteroscopy, or other imaging chosen by a clinician.

Male-factor infertility is common and often silent

Male-factor infertility contributes to a substantial proportion of couples who have difficulty conceiving. It may involve low sperm concentration, poor motility, abnormal morphology, impaired ejaculation, hormonal problems, obstruction, varicocele, genetic conditions, prior testicular injury, infections, heat exposure, medications, anabolic steroid use, or lifestyle factors. Importantly, sexual function and semen quality are not the same thing; a man can have normal erections and ejaculation but abnormal semen parameters.

A semen analysis is usually one of the earliest, simplest, and most informative tests in a fertility workup. It evaluates semen volume, sperm concentration, total sperm count, motility, and morphology. Abnormal results are commonly repeated because illness, fever, abstinence interval, lab variation, and recent exposures can temporarily affect results.

When abnormalities are persistent, a urologist or reproductive specialist may consider hormone testing, examination for varicocele, genetic testing in selected cases, or review of medications and occupational exposures. Early male

evaluation can prevent months of unnecessary uncertainty.

Hidden medical and lifestyle reasons that may be overlooked

Some causes of delayed conception are subtle. Thyroid disorders, elevated prolactin, insulin resistance, poorly controlled diabetes, autoimmune disease, celiac disease, chronic kidney or liver disease, and certain genetic conditions can affect ovulation, implantation, pregnancy maintenance, or sperm function. Past sexually transmitted infections can leave tubal or epididymal scarring even after treatment.

Medications and substances may also matter. Some chemotherapy agents, radiation, testosterone therapy, anabolic steroids, certain psychotropic medications, opioids, and some drugs affecting prolactin or sexual function can reduce fertility. Never stop prescribed medication on your own; instead, ask the prescribing clinician whether a preconception-safe alternative or adjustment is appropriate.

Lifestyle factors are rarely the only explanation, but they can influence reproductive physiology. Smoking is linked to reduced fertility and earlier ovarian aging. Heavy alcohol use, recreational drugs, significant sleep disruption, extreme exercise, underweight, obesity, and environmental heat exposure to the testes may reduce chances. Nutrition matters as part of overall metabolic health, but no supplement can reliably overcome a structural or hormonal fertility problem.

Timing errors and the fertile window

One of the most frustrating hidden reasons is that intercourse may not be occurring at the most fertile time, even when a person is tracking carefully. The fertile window includes the days before ovulation and the day of ovulation, because sperm can survive in the reproductive tract for several days, while the egg is viable for a much shorter period.

Ovulation predictor kits detect luteinizing hormone surge, but the surge does not always mean ovulation definitely occurred. Apps estimate ovulation based on previous cycles and can be wrong, especially with irregular cycles. Cervical mucus observations and basal body temperature can provide additional clues, but

each method has limitations.

For many couples, intercourse every 1 to 2 days during the fertile window is sufficient. If tracking is increasing stress or creating performance pressure, a clinician can help simplify the strategy. Correct timing improves probability, but it still cannot make pregnancy certain in any given cycle.

Unexplained infertility: real, not imaginary

Sometimes standard testing shows ovulation, open tubes, a normal uterine cavity, and semen parameters in the reference range, yet pregnancy still does not occur. This is often called unexplained infertility. The term can be unsatisfying, but it does not mean the difficulty is not real. It means current routine tests have not identified a specific cause.

Possible contributors may include subtle egg or sperm dysfunction, fertilization problems, embryo chromosomal abnormalities, tubal function issues not seen on patency testing, endometrial receptivity differences, or immune and inflammatory factors that are not routinely measurable. Management depends on age, duration of infertility, prior pregnancies, test results, and personal preferences.

For some people, expectant management may be reasonable for a period. Others may benefit from ovulation induction, intrauterine insemination, or in vitro fertilization. The right path is individualized and should be discussed with a qualified fertility professional.

What a fertility evaluation may include

A fertility workup is usually stepwise rather than one massive test panel. It often starts with a detailed history from both partners: cycle pattern, pregnancy history, surgeries, infections, medications, occupational exposures, sexual timing, pain symptoms, and family history. Physical examination may be recommended depending on context.

Common components include confirmation of ovulation, ovarian reserve testing, pelvic ultrasound, assessment of the uterine cavity and fallopian tube patency, and semen analysis. Additional tests may be used when indicated, such as

thyroid and prolactin levels, androgen testing, infectious disease testing, genetic tests, or evaluation by a reproductive urologist.

It is reasonable to ask your clinician what each test can and cannot tell you, how results may change management, and whether referral to a reproductive endocrinologist is appropriate. Good fertility care should be medically thorough and emotionally respectful.