LIVING WELL

How Long Should You Try Before Seeking Fertility Help?

The calendar matters, but age, menstrual changes, medical history and repeated pregnancy loss can all make an earlier conversation worthwhile.

The month that starts to feel different

At first, trying to become pregnant may feel hopeful and private. Then another period arrives. The calendar begins to carry more weight, and advice that once sounded simple-just give it time-can start to feel like an instruction to wait without knowing why.

There is a standard marker. Infertility is defined as not becoming pregnant after one year of trying. If the woman is over 35, that point shortens to six months. An important nuance is that the one-year definition is used for public-health data collection and is not meant, by itself, to dictate when every person should receive fertility care.

That distinction matters because a threshold is not a verdict. Reaching six months or a year does not tell you what is happening, whether a cause will be found or what comes next. It marks the point when continuing to wait without a medical conversation may no longer be the most useful approach.

It is also not rare territory. About 15% of couples are unable to become pregnant after a year of unprotected sex. Data from 2015-2019 found that 19.4% of married women ages 15 to 49 with no previous births met the measure of infertility. Statistics cannot explain your month. They can tell you that you are not uniquely failing.

The calendar is only one signal

Age changes the timing because female fertility declines steadily with age, according to the CDC. Egg quality declines over time, fewer eggs remain, and the chances of miscarriage and having a child with a genetic abnormality rise. That is why some providers begin evaluation after six months when the woman is 35 or older rather than waiting a full year.

Your periods can be another reason not to treat the one-year mark as a waiting requirement. The CDC says regular, predictable periods occurring every 21 to 35 days likely reflect ovulation, while irregular periods make it more likely that ovulation is not occurring. A

disruption in ovarian function calls for evaluation by a health care provider.

History matters too. Pelvic infection, a ruptured appendix, gonorrhea, chlamydia, endometriosis and previous abdominal surgery are among the CDC's listed risk factors for blocked fallopian tubes. Conditions affecting the ovaries, fallopian tubes or uterus can contribute to difficulty becoming pregnant. If one of these is already part of your story, you do not need to pretend the calendar is the only information you have.

Repeated pregnancy loss also changes the conversation. Infertility includes recurrent miscarriages or stillbirths, and reproductive endocrinologists may help after two or more spontaneous miscarriages. If pregnancies begin but repeatedly do not continue, this has already stopped being a question of simply trying longer. It deserves medical attention.

A threshold is not a verdict.

This is not one partner's test

Fertility worries often settle on the partner who would carry the pregnancy. The evidence does not support that focus. Infertility is traced to the woman about a third of the time and to the man about a third of the time. The remainder involves both partners, or no cause is found.

That means a sensible first conversation includes both partners where applicable. The CDC says male infertility may involve testicular or ejaculatory function, hormones or genetic conditions. Evaluation typically includes a medical history, physical examination and semen analysis, which looks at sperm concentration, movement and shape.

Even that test is not a one-line answer. The CDC cautions that a slightly abnormal semen result does not necessarily mean a man is infertile. It is information for a specialist to interpret, not a label to carry home alone.

Female evaluation can also involve more than one question because becoming pregnant requires several steps: release of an egg, fertilization by sperm, movement through a fallopian tube and implantation in the uterus. Tests may examine ovarian function, whether the fallopian tubes are open and the uterine environment. The CDC is explicit that no single test perfectly predicts fertility.

An appointment is not a treatment decision

Seeking help can sound like stepping onto a conveyor belt toward drugs, surgery or assisted reproductive technology. But an appointment begins with understanding what may be contributing. Tests may identify fertility problems; when a cause can be found, possible care

includes medicines, surgery or assisted reproductive technologies.

The words "when a cause can be found" deserve room. Sometimes none is found. That uncertainty can be disappointing, but inventing a clean explanation would not make the evidence stronger. An evaluation can narrow possibilities without delivering one decisive reason.

You may also encounter treatments promoted around a test result. For example, a 2023 systematic review examined clomiphene citrate for infertile men. Across 15 studies included in its meta-analysis, sperm concentration and total motility were higher during treatment, but sperm shape did not differ. The studies varied substantially, and reported pregnancy rates across 10 studies ranged from zero to 40%. Better semen measurements are not the same as a promised pregnancy.

The practical point is not to choose a treatment before your appointment. It is to arrive knowing that testing, interpretation and treatment are separate decisions. Ask what a result can establish, what it cannot establish, and whether the proposed next step is intended to change a laboratory measure or an outcome that matters to you.

Protect what trying has changed

By the time you seek help, sex may no longer feel entirely like sex. It can feel attached to a result, and each unsuccessful month can make intimacy harder to separate from the project of becoming pregnant. That strain is not evidence that you are handling this badly.

A 2020 systematic review found that infertility and its treatment negatively affected couples' sexuality and were associated with lower sexual satisfaction. Across the studies it reviewed, sexual dysfunction was reported by 43% to 90% of women and 48% to 58% of men. The authors concluded that couples might benefit from sexual therapy and support during fertility care, while noting that psychological interventions need further evaluation.

You do not need to wait for that strain to become a crisis before naming it. If trying or treatment is disrupting sexual wellbeing, bring that into the medical conversation alongside periods, pregnancies, health history and test results. It belongs there.

This week, look at the calendar without letting it be the only judge. Note how long you have been trying, the age of the partner who would carry the pregnancy, whether periods are irregular, whether there have been two or more miscarriages, and any relevant history for either partner. If you have reached a year, reached six months over age 35, or already have reasons for concern, make the appointment. The first step is a conversation, not a commitment.

Where this comes from

- Infertility

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