HOLISTIC FERTILITY®

WHY IS PREGNANCY NOT HAPPENING?

The Complete Guide to Fertility Evaluation

What to investigate, why it matters, what the results can tell you — and what they cannot.

A practical, evidence-informed guide

Holistic Fertility® Fertility Library

01

How to use this guide

A map, not a diagnosis.

When pregnancy is taking longer than expected, information can become another source of pressure. This guide is designed to help you understand the usual fertility evaluation, organise your questions and read results in context. It is not intended to diagnose you, replace a fertility specialist or tell you which treatment you need.

Important medical note

Fertility evaluation should be personalised by an appropriately qualified healthcare professional. Do not start, stop or change medication, supplements or treatment based on this guide. Seek urgent medical care for severe pain, heavy bleeding, fainting, fever or other acute symptoms.

What this guide will help you do

- Understand the core components of a fertility evaluation.
- Know what common tests are designed to answer.
- Avoid over-interpreting a single result.
- Prepare better questions for your clinician.

02

When should fertility evaluation begin?

Timing matters — but some situations deserve earlier assessment.

Professional guidance generally recommends evaluation after 12 months of regular unprotected intercourse when the female partner is under 35, after 6 months when she is 35 or older, and more promptly after 40. Evaluation should begin earlier when there is a known condition or history that may affect fertility.

Consider earlier evaluation when:

- Irregular or absent periods
- Known or suspected endometriosis
- Previous pelvic infection, pelvic surgery or tubal disease
- Known uterine abnormality or fibroids affecting the cavity
- Previous chemotherapy, radiotherapy or ovarian surgery
- Known male-factor concern or sexual/ejaculatory difficulty
- Recurrent pregnancy loss
- Any other known condition strongly associated with reduced fertility

Why timing matters

Evaluation is not about rushing into treatment. It is about avoiding unnecessary delay when time-sensitive factors may be present.

03

Fertility is a system

A complete evaluation looks at more than one person, one hormone or one scan.

A standard infertility evaluation typically addresses three broad questions at the same time: Is ovulation occurring? Are the reproductive tract and fallopian tubes structurally suitable and patent? Is there a male factor? Depending on history, age and findings, additional evaluation may be appropriate.

Ovulation	Is an egg likely to be released regularly?
Anatomy & tubes	Is the uterine cavity suitable and are the tubes open?
Sperm	Are sperm concentration, movement and other parameters adequate?

Parallel evaluation

Male and female factors can coexist. Evaluating one partner first and the other much later can waste time.

04

Cycle & ovulation

The menstrual cycle is useful information, but not every woman needs every hormone test.

For women with regular cycles of roughly 21–35 days, ASRM guidance notes that additional testing to confirm ovulation is usually not required unless there are specific clinical signs. Irregular or absent cycles can justify a more directed hormonal evaluation.

Useful history includes:

- Cycle length and regularity
- Bleeding pattern and significant pain
- Signs suggesting ovulation or anovulation
- Symptoms of androgen excess such as hirsutism
- History of very low weight, intense exercise, eating disorder or major weight change
- Symptoms that may suggest thyroid or prolactin disorders

Remember

A regular cycle is reassuring evidence of ovulatory function, but the whole history still matters.

05

AMH & ovarian reserve

Useful information — but not a fertility verdict.

AMH and antral follicle count (AFC) are useful markers of ovarian reserve, especially for estimating how the ovaries may respond to stimulation in fertility treatment. They are not reliable stand-alone tests of whether a woman can conceive naturally now or in the future.

The key distinction

Low AMH can mean fewer follicles are likely to respond during stimulation. It does not mean pregnancy is impossible. High AMH can predict a stronger ovarian response, but it does not guarantee egg quality, embryo competence or pregnancy.

Common ovarian-reserve markers

- AMH — can be measured across much of the cycle; mainly reflects follicular quantity.
- AFC — ultrasound count of small antral follicles, usually assessed early in the cycle.
- FSH + estradiol — often measured early in the cycle; interpretation depends on timing and context.

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Transvaginal ultrasound & AFC

A scan can answer several questions at once.

A transvaginal ultrasound can assess the ovaries, antral follicle count and the uterus. It may identify fibroids, ovarian cysts or other structural findings. The meaning of a finding depends on its size, location, symptoms and the rest of the fertility picture.

Do not confuse “found” with “caused”

A finding on ultrasound is not automatically “the cause.” Many common findings are incidental. The clinical question is whether it is likely to alter fertility or treatment.

What the scan may assess

- Ovarian morphology and antral follicles
- Uterine shape and endometrial appearance
- Fibroids, cysts or other structural findings

07

Fallopian tubes & uterine cavity

Open tubes matter for natural conception and IUI; the uterine cavity matters for implantation.

ASRM recommends HSG or sonographic approaches such as SHG/HyCoSy for evaluation of tubal patency when indicated. HSG uses contrast and X-ray imaging; ultrasound-based tests use fluid and/or contrast seen on ultrasound. The best test depends on history, availability and what else needs to be assessed.

- Tubal patency: can sperm and egg meet?
- Uterine cavity: are there polyps, submucosal fibroids, adhesions or congenital anomalies?
- Hydrosalpinx: a fluid-filled damaged tube can matter particularly before IVF.

HSG is not the only option

Your clinician may choose HSG, saline sonography or contrast-enhanced ultrasound depending on the clinical question and local expertise.

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Male factor & semen analysis

Fertility evaluation should be parallel, not sequential.

AUA/ASRM guidance recommends concurrent assessment of both partners and one or more semen analyses as part of the initial male evaluation. Semen parameters vary naturally, and a single result above or below a reference limit does not by itself prove fertility or infertility.

- Concentration / sperm count
- Motility
- Morphology
- Semen volume and other laboratory observations
- Reproductive, sexual and medical history

One result is not the whole story

If semen analysis is abnormal, repeat testing and evaluation by a clinician with expertise in male reproduction may be appropriate. Male-factor assessment can reveal treatable conditions and sometimes broader health issues.

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Hormones: test what the history justifies

More testing is not automatically better testing.

Hormonal testing is targeted to the clinical picture. Depending on menstrual pattern and symptoms, clinicians may consider TSH, prolactin, androgens, progesterone or other tests. Broad panels without a clinical question can create confusing results that do not change management.

- TSH — when thyroid dysfunction is suspected or clinically relevant
- Prolactin — particularly with irregular/absent cycles, galactorrhoea or suggestive symptoms
- Androgens — when PCOS or androgen excess is suspected
- Progesterone — may be used in selected contexts to support evidence of ovulation

A test needs a question

Ask: “What are we looking for, and what would we do differently if this result is abnormal?”

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Age & fertility

Age changes probability — it does not write an individual destiny.

Female fertility declines with age because both oocyte number and the probability of chromosomally competent oocytes decline. This is why age remains a stronger general predictor of reproductive outcome than AMH alone. Population statistics are useful for counselling, but they do not precisely predict one woman’s next cycle.

A better question

The useful question is not “Am I too old?” It is “Given my age, history, ovarian response and the rest of our evaluation, what are the realistic options and time-sensitive decisions for me?”

When the answer is “unexplained”

Unexplained infertility is a diagnosis after standard evaluation — not a claim that the problem is “in your head.”

If ovulation appears to occur, at least one tube is open, the uterine evaluation is reassuring and semen analysis is adequate, no clear cause may be identified. That does not mean there is no biological explanation; it means routine testing has not identified one that clearly changes treatment.

Unexplained ≠ psychological

Holistic or emotional support can be valuable during unexplained infertility, but it should never be used to invent a psychological cause that medical evaluation has not found.

What “unexplained” usually means

- Standard evaluation is broadly reassuring.
- No single treatable cause has been identified.
- Treatment decisions rely more heavily on age, duration of infertility and prognosis.

What fertility tests cannot tell you

Knowing the limits of a test is as important as knowing the result.

- AMH cannot tell you the exact quality of your eggs.
- No ovarian-reserve test can precisely predict natural conception for an individual woman.
- A normal semen analysis does not guarantee conception; an abnormal one does not automatically mean conception is impossible.
- An open tube does not prove normal tubal function in every respect.
- A normal basic evaluation does not rule out every possible biological factor.
- One laboratory value should rarely be interpreted outside age, history and the rest of the evaluation.

The most dangerous interpretation

Turning one number into a verdict about your body, your future or your worth.

Read the results together

The goal is a clinical picture, not a folder full of isolated numbers.

The most useful fertility consultation connects the pieces: age and duration of trying, cycle pattern, ovarian reserve, anatomy, semen analysis, pregnancy history, symptoms, previous treatment and your priorities. Two women with the same AMH can have very different clinical situations.

A useful clinical summary often contains:

- Age and duration of trying
- Cycle/ovulation history
- Ovarian reserve in context
- Tubal and uterine assessment
- Semen analysis / male evaluation
- Pregnancy and treatment history

Questions worth taking to your appointment

Good questions improve clarity and reduce the chance of leaving with more confusion.

- ☐ What are the most likely explanations in my case?
- ☐ Which parts of the standard evaluation have been completed, and what is still missing?
- ☐ What does my AMH/AFC mean for me specifically — and what does it not mean?
- ☐ Is there a male factor that needs repeat testing or specialist review?
- ☐ Do I need a tubal-patency or uterine-cavity test? Why this test?
- ☐ Which results would actually change our treatment plan?
- ☐ Are any proposed tests or “add-ons” optional? What evidence supports them?
- ☐ What is a realistic prognosis given my age, duration of infertility and history?
- ☐ How long is it reasonable to continue trying before changing strategy?
- ☐ If the next step fails, what would we reconsider?

My fertility evaluation checklist

Use this page as a simple record. It is not a prescription for which tests you personally need.

☐ Cycle history reviewed

☐ Ovulation status assessed if indicated

☐ AMH / ovarian reserve discussed in context

☐ Transvaginal ultrasound / AFC if indicated

☐ Tubal patency assessed if indicated

☐ Uterine cavity assessed if indicated

☐ Semen analysis completed

☐ Repeat semen analysis / male specialist if indicated

☐ Thyroid / prolactin / other hormones if indicated

☐ Pregnancy-loss history reviewed

☐ Previous treatment records reviewed

☐ Medication / supplement list reviewed

☐ Questions and next-step plan written down

When evaluation should not wait

Some histories deserve earlier specialist discussion.

- Age over 40 and trying to conceive
- Amenorrhoea or markedly irregular cycles
- Known severe endometriosis or prior ovarian surgery
- Known bilateral tubal disease or significant pelvic infection history
- Cancer treatment that may affect fertility
- Known severe male-factor infertility
- Two or more pregnancy losses
- Any condition for which delay may materially reduce options

Earlier evaluation is not the same as immediate treatment

It means getting the right information before time-sensitive options narrow.

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The evaluation is medical. The experience is human.

You can be evidence-based and still need support.

Tests can organise information, but they do not remove uncertainty. Waiting, comparing yourself with others, repeated appointments and difficult results can affect sleep, relationships, sexuality and your sense of trust in your body. Support for this burden has value in its own right. It should complement — not replace — medical evaluation.

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Complementary support can address stress, emotional burden and the relationship with your body while remaining aligned with medical evaluation and treatment.

Your next step

From information to a clear plan.

Bring your records together, identify what has already been evaluated, write down your questions and ask your clinician what information would genuinely change the next decision. The objective is not to perform every possible test. It is to obtain enough reliable information to make the next decision with greater clarity.

Knowledge does not make the decision for you. It helps you make your own.

Before your next appointment

☐ Collect previous test results and treatment records

☐ Write your three most important questions

☐ Ask which result would change the next decision

☐ Write down the agreed next step

Core scientific sources

Selected authoritative guidance used to build this guide.

ASRM — Fertility evaluation of infertile women: a committee opinion (2021)

ACOG — Evaluating Infertility

ASRM — Testing and interpreting measures of ovarian reserve (2020)

ASRM / ReproductiveFacts — Diagnostic Testing for Infertility

ASRM / ReproductiveFacts — Hysterosalpingogram (HSG)

AUA/ASRM — Diagnosis and treatment of infertility in men, Part I

ASRM — Definition of infertility: a committee opinion (2023)

ASRM — Optimizing natural fertility: a committee opinion (2022)

HFEA — Preparing for your fertility clinic appointment

Editorial principle

We distinguish what is well established, what is useful only in a specific clinical context, and what remains uncertain.

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