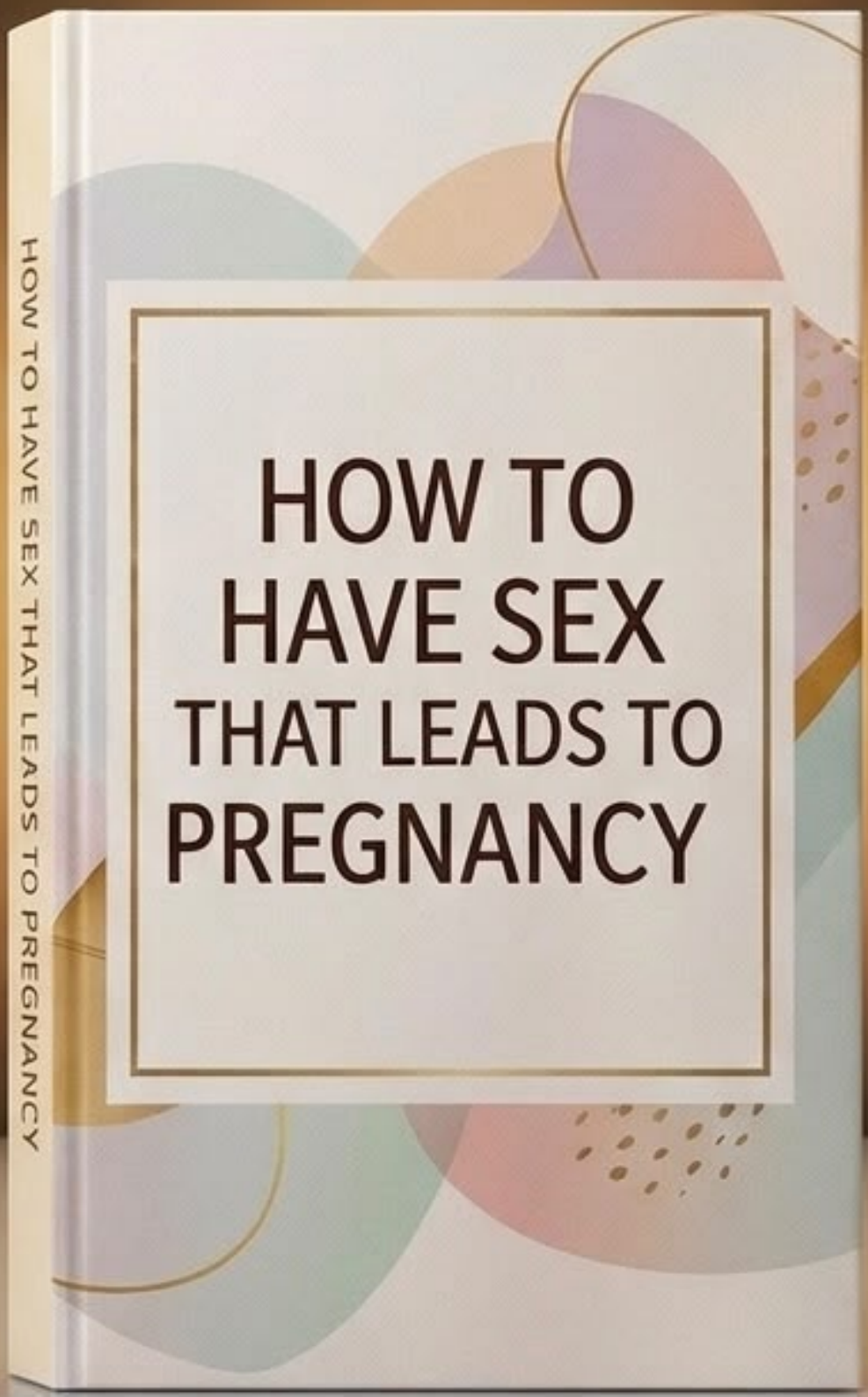

HOW TO HAVE SEX THAT LEADS TO PREGNANCY
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> **Medical note**
> This guide is for educational purposes. Consult a healthcare professional before making changes to your health routine, medications, supplements, or fertility care. No method in this guide can guarantee pregnancy.



INTRODUCTION

You May Not Need More Sex. You May Need Better Timing.

You have decided you want a baby. So you stop contraception, start having sex more often, and perhaps download an ovulation app. Someone tells you Day 14 is the day. Another person says missionary position is best. Someone else insists you should put a pillow under your waist and raise your legs afterward.

Then your period comes. You try again. Another period comes. Suddenly something that was supposed to feel exciting starts becoming confusing.

- Are we having sex on the wrong days?
- Are we doing it often enough?
- Should we be doing it every day?
- Am I actually ovulating?
- Does semen leaking out mean the attempt failed?
- Is there really a best position?
- How long should we keep trying before getting help?

These are reasonable questions. Fertility is one of those subjects where useful medical guidance sits right beside an enormous amount of folklore. This book is designed to separate the two.

First, One Important Truth

There is no sexual position, food, pillow arrangement, post-sex ritual, supplement, or secret technique proven to guarantee pregnancy. What you can do is improve the biological

opportunity for conception.

- an egg must be released

- viable sperm must be available

- sperm and egg must be able to meet

- intercourse must occur close enough to ovulation for fertilization to be possible

The American Society for Reproductive Medicine (ASRM) describes the fertile window as the approximately six-day interval ending on the day of ovulation. ASRM also reports that conception probability is highest during the days immediately before ovulation.

KEY IDEA
Your goal is not to catch one magical minute. Your goal is to cover the days when conception is biologically possible.

Why Sex Before Ovulation Matters

ACOG explains that sperm can survive in the female reproductive tract for as long as about five days, while an egg usually remains fertilizable for only around 12 to 24 hours after ovulation. That is why sex before ovulation matters.

If ovulation happens on Thursday, sex on Tuesday may mean viable sperm are already present when the egg is released. Waiting until Friday may mean the most useful part of the window has already passed.

Everyone Does Not Ovulate on Day 14

Cycle Day 1 is the first day of menstrual bleeding. ACOG explains that ovulation often occurs roughly 14 days before the next menstrual period, rather than automatically on the fourteenth day after the previous period started. Shorter and longer cycles can therefore shift the likely ovulation day.

This Is Not Only About the Woman

The AUA/ASRM male infertility guideline recommends concurrent evaluation of both partners when infertility is being investigated. Male fertility factors can involve sperm production, sperm movement, reproductive anatomy, ejaculation, hormones, medication use, previous illness, and other issues.

BRIDGE TO CHAPTER 1
You do not need to memorize reproductive medicine before you can take useful action. In the next chapter, you will turn your recent cycle dates into a practical 30-minute plan.



CHAPTER 1

The 30-Minute Fertility Window Setup

"Keep trying" is not a strategy. In the next 30 minutes, you are going to turn your recent menstrual history into something practical.

You will need your phone or calendar, the start dates of your recent periods if available, a pen or notes app, and ideally your partner's calendar.

Step 1: Find Your Real Day 1

Cycle Day 1 is the first day of your menstrual period. If your period started on August 3, August 3 is Day 1, August 4 is Day 2, and so on.

> **WRITE IT DOWN**
> The first day of my most recent period was: _____

Step 2: Calculate Your Recent Cycle Lengths

A menstrual cycle is measured from the first day of one period to the first day of the next.

Cycle	Period start	Next period	Length
1	_____	_____	_____ days
2	_____	_____	_____ days
3	_____	_____	_____ days

Recent average cycle length: _____ days

Step 3: Estimate Ovulation

A rough planning method is: **average cycle length - 14 = estimated ovulation day.** This reflects ACOG's explanation that ovulation commonly occurs roughly 14 days before the next period.

- 21-day cycle: around Day 7
- 26-day cycle: around Day 12
- 28-day cycle: around Day 14
- 30-day cycle: around Day 16
- 32-day cycle: around Day 18
- 35-day cycle: around Day 21

> **IMPORTANT**
> Circle the word estimated. A calendar can suggest when ovulation may occur. It cannot prove that ovulation happened on that exact day.

Step 4: Build Your Approximate Fertile Window

ASRM describes the fertile window as approximately six days ending on ovulation day. Take your estimated ovulation day and count backward five days.

Relative day	Cycle day/date
5 days before	_____
4 days before	_____
3 days before	_____
2 days before	_____
1 day before	_____
Estimated ovulation	_____

Step 5: Choose Your Intercourse Strategy

Option A - Low pressure: NICE advises vaginal intercourse every two to three days as a practical way of optimizing the chance of pregnancy.

Option B - Fertile-window focus: ASRM reports that intercourse every one to two days during the fertile window is associated with the highest pregnancy rates.

Step 6: Add One Real-Time Fertility Sign

ACOG explains that cervical mucus often becomes wetter, clearer, more slippery, and more stretchy close to ovulation. Once a day is enough for a beginner tracker.

Date	Observation
_____	Dry / Sticky / Creamy / Wet / Slippery-clear-stretchy
_____	Dry / Sticky / Creamy / Wet / Slippery-clear-stretchy
_____	Dry / Sticky / Creamy / Wet / Slippery-clear-stretchy
_____	Dry / Sticky / Creamy / Wet / Slippery-clear-stretchy

Step 7: Make the Plan Together

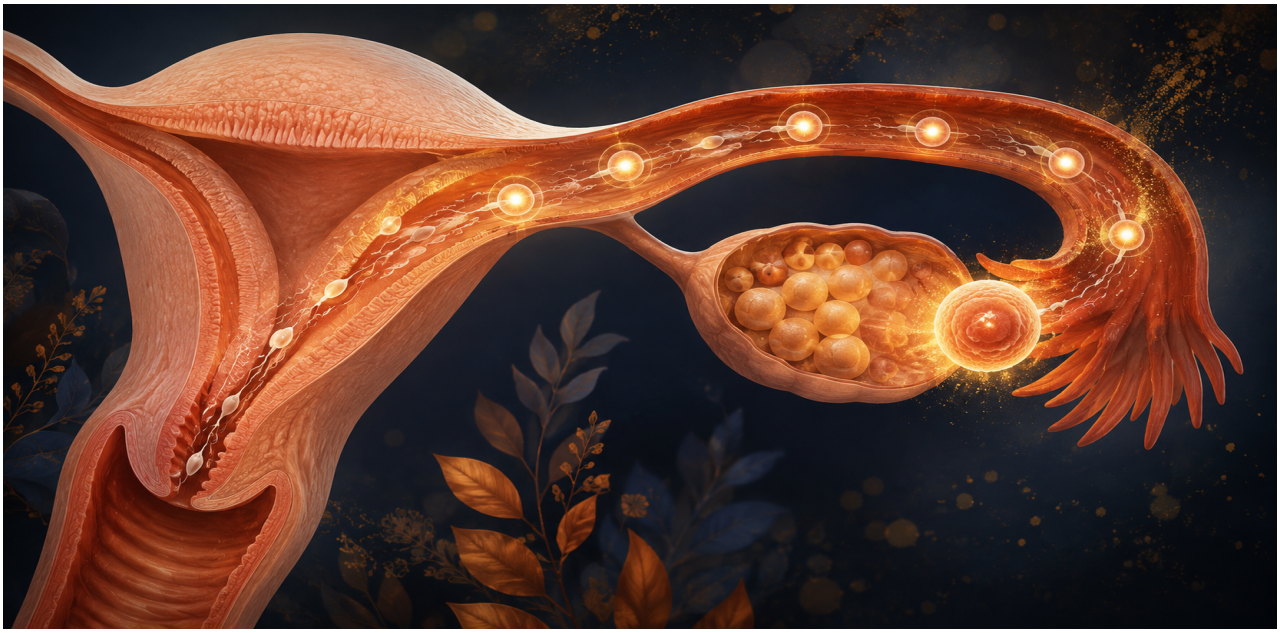
Try: "It looks like my likely fertile window is between _____ and _____. I would like us to try every day or every other day around then without making it stressful. What feels realistic for us?"

30-MINUTE QUICK WIN

0-5 min: find period dates. 5-10 min: calculate cycle lengths. 10-15 min: estimate ovulation. 15-20 min: mark the fertile window. 20-25 min: choose intercourse dates. 25-28 min: record cervical mucus. 28-30 min: share the plan with your partner.

NEXT

Knowing the dates is only the beginning. Chapter 2 explains why those six days matter, so timing sex becomes less mysterious and more practical.



CHAPTER 2

The Six Days That Matter Most

The fertile window exists because sperm and egg have different biological timelines. ACOG states that sperm can remain capable of fertilization in the female reproductive tract for up to about five days, while an egg typically remains fertilizable for only about 12 to 24 hours after ovulation.

Think of Sperm as Arriving Early

One simple way to understand fertility timing is to imagine the egg has a very short appointment window. You do not want sperm arriving after the appointment is over. You want them already present.

If ovulation is expected on Day 16, do not wait for Day 16 to begin trying. Start earlier and cover the window.

Are All Six Days Equally Fertile?

No. ASRM's review of natural fertility research indicates that conception probability changes across the fertile window and is highest close to ovulation, particularly during the one to two days beforehand.

PRACTICAL RULE
Begin covering the window early enough and continue through the most fertile days.

What Happens After Ejaculation?

After semen is deposited in the vagina, sperm begin moving through the cervix and upper reproductive tract. Not every sperm reaches the site where fertilization may occur, and that is

normal. Visible semen leakage after sex cannot tell you whether sperm have already moved into the reproductive tract.

Your Six-Day Coverage Map

Relative day	Date	Planned sex	Completed
-5	_____	[ ]	[ ]
-4	_____	[ ]	[ ]
-3	_____	[ ]	[ ]
-2	_____	[ ]	[ ]
-1	_____	[ ]	[ ]
Estimated ovulation	_____	[ ]	[ ]

NEXT
Now that you understand the window, the next question is obvious: how do you know whether ovulation is actually approaching? Chapter 3 gives you four useful tools.



CHAPTER 3

How To Know When You're Ovulating

Calendar estimates are useful, but they are still estimates. Four common tools can add more information: cervical mucus, ovulation predictor kits, basal body temperature, and menstrual-cycle tracking.

1. Cervical Mucus

ACOG describes mucus near ovulation as typically becoming thinner, clearer, wetter, slippery, and stretchy. The useful thing to watch is change in your own pattern, not whether yours looks exactly like somebody else's.

- D = Dry
- S = Sticky
- C = Creamy
- W = Wet
- SL = Slippery / clear / stretchy

2. Ovulation Predictor Kits

Ovulation predictor kits (OPKs) usually detect a rise in luteinizing hormone (LH) in urine. The LH surge normally occurs before ovulation, so a positive result can help you prioritize intercourse around that time. Follow the instructions for your specific product.

LIMITATION
A positive OPK detects a hormonal signal associated with approaching ovulation. It does not guarantee that an egg was successfully released.

3. Basal Body Temperature

Basal body temperature (BBT) is your resting temperature measured under consistent conditions. After ovulation, progesterone can cause a small sustained temperature increase. BBT is therefore more useful for recognizing that ovulation probably already happened than for warning you early enough to begin intercourse.

4. Menstrual History

After several months, patterns may emerge. Your cycle length, mucus changes, OPK pattern, and temperature shift can sometimes give you a clearer picture together than any single tool alone.

Fertility Detective Tracker

Day	Date	Mucus	OPK	BBT	Sex	Notes
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						

Day	Date	Mucus	OPK	BBT	Sex	Notes
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
32						
33						
34						
35						

NEXT
Tracking should help you act, not give you a second job. Chapter 4 settles the next big question: exactly how often should you have sex?



CHAPTER 4

Exactly How Often Should You Have Sex?

> **SHORT ANSWER**
> Intercourse every one to two days during the fertile window is an evidence-based approach for maximizing natural conception chances.

ASRM supports this frequency based on available natural fertility evidence. That does not mean you must have sex every day, and it certainly does not mean multiple times per day is required.

Three Practical TTC Rhythms

1. Low pressure: Have vaginal intercourse every two to three days throughout the cycle. This is consistent with NICE guidance and reduces the need to predict ovulation precisely.

2. Fertile-window focus: Identify the likely fertile window and have intercourse approximately every other day.

3. Daily during peak days: Have intercourse daily during the most fertile days if both partners are comfortable and want to.

Do Men Need to Save Sperm?

For couples trying naturally, ASRM does not recommend routinely restricting intercourse frequency. There are situations where a clinician or laboratory may give specific abstinence instructions for semen testing or fertility treatment. Follow those instructions when they apply.

What If Real Life Gets in the Way?

There are night shifts, children, travel, deadlines, traffic, and simple exhaustion. That is precisely why the fertile window is useful. If you miss one day, return to the plan on the next suitable day rather than declaring the cycle ruined.

Choose Your TTC Rhythm

[ ] Every 2-3 days throughout the cycle

[ ] Every other day during the fertile window

[ ] Daily around the most fertile days when comfortable

Likely fertile window: _____ to _____

Best realistic dates: 1. _____ 2. _____ 3. _____ 4. _____

> **NEXT**
> You now know when and how often. Chapter 5 tackles the advice people usually hear first: positions, raised legs, pillows, leakage, urination, and orgasm.



CHAPTER 5

Missionary, Doggy, Legs Up? Fertility Myths About Sex

Is There a Best Sex Position for Pregnancy?

ASRM notes that there is no evidence establishing specific intercourse positions as improving natural fertility. Missionary position has not been proven to be the fertility winner, and neither has any other position.

The practical priority is vaginal intercourse with ejaculation during the fertile window. Choose positions that are comfortable, consensual, and sustainable.

Should You Put a Pillow Under Your Hips?

There is no established evidence that elevating your hips after intercourse improves natural pregnancy rates. If lying down for a few minutes feels comfortable, that is fine, but it should not become a fertility rule.

Do You Need to Raise Your Legs?

No established evidence shows that putting your legs against the wall improves natural conception. You may officially retire the fertility gymnastics.

What If Semen Leaks Out?

Visible post-intercourse fluid does not tell you that all sperm were lost. Sperm begin moving into cervical mucus and the reproductive tract soon after ejaculation. The fluid you see afterward is not a measure of whether conception can occur.

Should You Avoid Urinating After Sex?

No. Urine exits through the urethra. Sperm involved in conception travel from the vagina through the cervix into the reproductive tract. These are different anatomical pathways.

Does the Woman Need to Orgasm?

Female orgasm is not required for pregnancy. Pleasure and connection matter, but conception does not require the woman to orgasm.

Does Deeper Penetration Mean Better Fertility?

There is no established evidence that unusually deep penetration is required for natural conception. If intercourse hurts, do not tolerate pain because you believe deeper penetration gives sperm a special advantage. Persistent painful intercourse deserves medical attention.

MYTH CHECK
Replace position rules, raised-leg rituals, and leakage panic with better priorities: fertile timing, regular intercourse, comfort, consent, and appropriate medical evaluation.

NEXT
Once you stop performing unnecessary rituals, intercourse becomes simpler. Chapter 6 deals with one practical bedroom issue that should not be ignored: lubrication.



CHAPTER 6

Lubricants: The Small Detail Couples Often Miss

Trying to conceive can increase intercourse frequency. More frequent sex can make dryness or friction more noticeable, which is why lubricant becomes part of the fertility conversation.

What the Research Actually Says

ASRM notes that some lubricants have shown adverse effects on sperm parameters in laboratory studies. However, ASRM also notes that observational studies have not clearly demonstrated reduced natural fecundability among lubricant users overall.

> **BALANCED VIEW**
> Some products may affect sperm in laboratory conditions, but that does not automatically mean every lubricant prevents pregnancy in real-world use.

A Sensible TTC Approach

If you need lubricant while trying to conceive, choose a product specifically intended for TTC use or one that provides appropriate sperm-compatibility information. Follow the manufacturer's directions and use enough for comfort.

Do not assume that "natural," "organic," or homemade automatically means fertility-friendly. Those words are not substitutes for fertility evidence.

Pain Is Not a Fertility Strategy

Avoiding lubricant is not helpful if intercourse becomes painful enough that you stop wanting sex. Persistent pain during intercourse can have different causes and deserves medical assessment.

TTC Lubricant Checklist

[ ] Is the product intended for intercourse?

[ ] Does it provide TTC or sperm-compatibility information?

[ ] Are ingredients and instructions clear?

[ ] Am I choosing it because of credible information rather than a viral claim?

[ ] Seek professional advice if intercourse is repeatedly painful or dryness is persistent or severe.

NEXT
We have dealt with several things that happen inside the bedroom. Chapter 7 moves the spotlight to the other half of conception: male fertility.



CHAPTER 7

His Fertility Matters Too

When pregnancy does not happen, the woman is often the first person who starts tracking, testing, changing food, buying supplements, counting days, and questioning her body. Meanwhile, nobody has asked a single question about sperm. That needs to change.

Male Fertility Belongs in the Conversation

The AUA/ASRM guideline recommends concurrent evaluation of both partners during an infertility investigation. Initial male assessment commonly includes a reproductive history and semen analysis.

A semen analysis can evaluate characteristics including sperm concentration, motility, and morphology. Results still need to be interpreted in clinical context.

Relevant Male Fertility History

- previous pregnancies
- testicular injury or undescended testicles
- genital or reproductive surgery
- infection or cancer treatment
- erectile or ejaculatory problems
- medications, testosterone, or anabolic steroids
- smoking, recreational drugs, alcohol, and general health

Testosterone Deserves Special Attention

The AUA/ASRM male infertility guideline cautions that external testosterone can suppress the hormonal signals required for normal sperm production. Men trying to conceive should disclose testosterone or anabolic steroid use to their clinician.

IMPORTANT
Do not stop prescribed medication without medical guidance. Libido and sperm production are not the same thing.

His Fertility Check

[ ] Smoking or recreational drug use reviewed

[ ] Excessive alcohol use reviewed

[ ] Prescription medicines reviewed

[ ] Testosterone or anabolic steroid use disclosed

[ ] Previous pregnancy and reproductive history recorded

[ ] Testicular injury, surgery, infection, or cancer treatment recorded

[ ] Erectile or ejaculatory problems discussed

[ ] Ask whether semen analysis is appropriate if evaluation is needed

NEXT
Once both partners are included, the next logical step is preparation. Chapter 8 focuses on evidence-based preconception health rather than miracle fertility products.



CHAPTER 8

Prepare the Body Before the Positive Pregnancy Test

Trying to conceive attracts miracle promises: eat this food, drink this tea, take this powder, avoid this ingredient. Most people do not need a kitchen full of fertility products. They need sensible preconception care.

Start Folic Acid Before Pregnancy

The CDC recommends that women who can become pregnant get 400 micrograms of folic acid daily. Adequate folic acid before and during early pregnancy helps reduce the risk of neural-tube defects. Some people need a different dose because of medical history or medication use, so individualized advice matters.

Review Medications Before Pregnancy

ACOG and NHS preconception guidance advise reviewing medication use when planning pregnancy. Do not simply stop a prescription because you read that a medicine might be unsafe. Stopping necessary treatment may also create risk.

> **ASK YOUR CLINICIAN**
> We are trying to conceive. Is this medication appropriate before and during pregnancy, or do we need another plan?

Smoking, Recreational Drugs, and Alcohol

Preconception care includes reviewing tobacco, alcohol, and recreational drug use. The purpose is risk reduction, not judgment. If stopping is difficult, ask for professional support.

Weight and Chronic Health

ACOG recommends addressing general health and chronic conditions before pregnancy where possible. Both very low and high body weight can be associated with reproductive and pregnancy concerns. The goal is sustainable health, not a crash diet.

What About Fertility Foods?

No single food has been proven to guarantee ovulation, fertilization, implantation, or pregnancy. Build your diet around overall nutritional quality: vegetables, fruits, whole grains, appropriate protein sources, healthy fats, and adequate hydration.

30-Day Preconception Checklist

[ ] Confirm appropriate folic acid guidance

[ ] List prescriptions, over-the-counter medicines, supplements, and herbal products

[ ] Arrange medication review if needed

[ ] Record Cycle Day 1 and begin fertility tracking

[ ] Address smoking and recreational drug use

[ ] Review alcohol use

[ ] Review chronic conditions and vaccination status where appropriate

[ ] Discuss persistent pelvic pain or abnormal bleeding

[ ] Both partners choose sustainable movement, sleep, and general health habits

[ ] Decide when professional evaluation will be sought if pregnancy does not occur

NEXT
Preparation improves the quality of the process. But if the cycle itself is unpredictable, generic formulas become less useful. Chapter 9 shows you what to do instead of endlessly guessing.



CHAPTER 9

What If Your Periods Are Irregular?

The simple calendar approach works best when cycles are reasonably predictable. If one cycle lasts 27 days, another 46, another 31, and then a period disappears completely, subtracting 14 from an average may create false confidence.

Why Irregular Cycles Matter

Irregular or absent periods may sometimes reflect irregular ovulation. ASRM notes that menstrual history is an important part of fertility evaluation and that conditions associated with irregular ovulation can warrant earlier assessment.

- polycystic ovary syndrome
- thyroid disorders
- significant weight change
- extreme exercise
- endocrine disorders
- certain medications
- age-related reproductive changes

DO NOT SELF-DIAGNOSE
Several different conditions can create similar cycle patterns. Persistent irregularity deserves appropriate clinical assessment.

Should You Just Buy More OPKs?

Not necessarily. Someone with highly unpredictable cycles may end up testing for long periods without gaining much clarity. Some hormonal conditions can also complicate interpretation.

Irregular-Cycle Record

Item	Record
Last six period start dates	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____
Shortest cycle	_____ days
Longest cycle	_____ days
Periods skipped?	Yes / No
Unusually heavy bleeding?	Yes / No
Bleeding between periods?	Yes / No
Significant pelvic pain?	Yes / No
Current medications	_____
Major recent weight change?	Yes / No
Known PCOS / thyroid / endocrine condition?	Yes / No
How long trying?	_____

NEXT
If cycles are absent or substantially irregular, another app may not be the answer. Chapter 10 asks the harder question: what if your timing looks good and pregnancy still does not happen?



CHAPTER 10

We Did Everything Right. Why Aren't We Pregnant?

You found your likely fertile window. You used OPKs. You had regular intercourse. You stopped worrying about positions. Months passed. Still no pregnancy. At this point, the solution may no longer be improve the timing.

Good Timing Cannot Correct Every Fertility Problem

ASRM recommends that infertility evaluation consider ovulation, reproductive anatomy, and tubal patency, while male evaluation includes semen assessment. Natural conception requires more than well-timed sex.

- absent or irregular ovulation
- some tubal blockages
- some sperm-production or delivery problems
- significant reproductive anatomy issues
- other medical causes of infertility

Ovulation Problems

Some women do not ovulate regularly. Clues can include absent or highly irregular periods, although symptoms alone cannot diagnose the underlying cause.

Tubal Factors

WHO notes that infertility can result from tubal disorders, including blockage related to reproductive-tract infection or other pelvic conditions. You cannot determine whether the fallopian tubes are open from an app, OPK, cervical mucus, or sexual position.

Endometriosis and Pelvic Conditions

Endometriosis is associated with infertility in some individuals. Fibroids and other uterine conditions may also affect fertility depending on individual circumstances. Persistent pelvic pain, very painful periods, or painful intercourse deserve clinical discussion rather than self-diagnosis.

Male Factors

Male infertility can involve sperm production, concentration, movement, reproductive obstruction, hormones, ejaculation, or other factors. This is why professional evaluation should not focus automatically on the woman.

What If Standard Testing Finds Nothing?

Sometimes no obvious explanation is identified after standard fertility evaluation. This is commonly called unexplained infertility. Unexplained does not mean imaginary; it means available testing has not identified a clear cause.

NEXT
If timing is reasonably good and pregnancy still does not occur, the next step may be more information rather than more intercourse. Chapter 11 tells you when to make that shift.



CHAPTER 11

When Should You Get Fertility Help?

Knowing when to seek help is part of trying intelligently. It is not admitting defeat.

If the Female Partner Is Under 35

ASRM generally recommends infertility evaluation after approximately 12 months of regular unprotected intercourse without pregnancy when the female partner is younger than 35 and there are no reasons to investigate sooner.

If She Is 35 or Older

ASRM recommends evaluation after approximately six months of unsuccessful trying for women aged 35 and older. The shorter timeline reflects the importance of age in female fertility.

If She Is Over 40

ASRM advises that more immediate evaluation may be appropriate for women over 40. Do not assume everyone should try for a full year before asking for help.

When You Should Not Necessarily Wait

- absent periods
- substantially irregular cycles
- known or suspected endometriosis
- known tubal disease or significant previous pelvic infection
- reproductive surgery

- previous chemotherapy or radiation
- known male infertility or significant testicular problems
- sexual dysfunction that prevents regular intercourse
- recurrent pregnancy loss

Take This to Your Doctor

Topic	Notes
How long trying?	_____
Intercourse frequency	_____
Timing methods	Calendar / mucus / OPK / BBT / app / none
Typical cycle length	_____ days
Shortest / longest recent cycle	_____ / _____ days
Periods regular?	Yes / No
Significant pelvic pain?	Yes / No
Previous pregnancy / loss	_____
Female medical history	PCOS / endometriosis / fibroids / thyroid / pelvic infection / surgery / cancer treatment
Male history	testicular injury / undescended testicle / surgery / cancer treatment / testosterone / steroid history / sexual function
Medications and supplements	_____

QUESTIONS TO ASK
Do we need confirmation of ovulation? Is semen analysis appropriate? Should tubal patency be evaluated? Are any medications relevant? What testing is appropriate now? What happens next if initial testing is normal?

NEXT
Once you have a medical threshold, you do not need to live in an endless loop of one more month. Chapter 12 protects another part of TTC that matters: your relationship.



CHAPTER 12

Stop Letting Baby-Making Kill Your Sex Life

At first, trying for a baby can feel exciting. Then the calendar appears. Sex becomes Tuesday, 9 p.m., must perform. The OPK is positive. One partner is exhausted. The other is anxious.

That is where fertility planning can begin hurting the relationship it was supposed to grow.

Timed Sex Is Still Sex

Consent does not disappear because somebody is ovulating. Neither partner owes intercourse on demand because an app says high fertility. The fertile window usually gives you several opportunities. Use that flexibility.

Have the Conversation Before the Window

Try: "My fertile period may start this weekend. How do we want to approach it without making ourselves miserable?"

- work schedules
- travel
- fatigue
- how much tracking to use
- how often you realistically want sex
- how either person can say tonight is not working

Stop Scoring Every Encounter

Avoid running a fertility audit after sex. Questions about whether it was deep enough, whether enough semen stayed inside, whether you lay down long enough, or whether the position was perfect create anxiety without improving evidence-based timing.

USEFUL QUESTIONS
Was intercourse reasonably timed? Are we covering the window? Is intercourse comfortable? Are we approaching this as a team?

Our TTC Agreement

Question	Our answer
How much tracking feels healthy?	_____
Preferred fertile-window frequency	_____
If one of us is exhausted	_____
How we will avoid pressure	_____
How we will maintain non-baby intimacy	_____
If we miss a planned day	_____
Daily fertility-discussion limit	_____ minutes
Planned evaluation threshold	_____

NEXT
You now have the biology, timing, tracking tools, medical thresholds, and relationship plan. The final chapter turns all of it into one repeatable 90-day system.



FINAL CHAPTER

Your 90-Day Conception Plan

At this point, you do not need more random fertility advice. You need consistency. For the next three cycles, where medically appropriate, use one repeatable system instead of reinventing your strategy every month.

Phase 1: Reset

[ ] Mark Cycle Day 1

[ ] Record the previous cycle length

[ ] Review the previous tracker

[ ] Note unusual bleeding, pain, or cycle changes

Ask: Did our estimated window roughly match mucus or OPK signs? Did we actually have sex during that window? Did tracking help us or make us more anxious? Is anything happening that deserves medical attention?

Phase 2: Prepare

[ ] Review the likely fertile window

[ ] Put dates in both calendars

[ ] Check OPK supplies if using them

[ ] Continue appropriate preconception care

[ ] Review travel and work conflicts

[ ] Make sure intercourse is comfortable

[ ] Talk with your partner

Phase 3: Cover the Window

[ ] Watch cervical mucus if useful

[ ] Use OPKs if part of your plan

[ ] Aim for intercourse every one to two days if comfortable

[ ] Adjust around real life

[ ] Do not obsess over sexual positions

[ ] Do not perform unnecessary post-sex rituals

[ ] Do not judge the attempt by semen leakage

> **REMEMBER**
> Your job is coverage, not perfection.

Phase 4: After Ovulation

Every cramp can start to feel like implantation and every sensation can feel like a pregnancy symptom. Early pregnancy symptoms can overlap with ordinary premenstrual symptoms. Follow the instructions of the pregnancy test you use and seek healthcare advice when appropriate.

Phase 5: Review

If your period begins, record the cycle length, estimated fertile window, intercourse dates, positive OPK if used, most fertile-type mucus, and anything unusual. Then ask: What did this cycle teach us? Not: Who failed?

Your 90-Day TTC Dashboard

MONTH 1

Item	Record
Period started	_____
Cycle length	_____ days
Estimated fertile window	_____
Intercourse dates	_____
Positive OPK	_____
Most fertile mucus	_____
Pregnancy test / result	_____

Item	Record
What we learned	_____

MONTH 2

Item	Record
Period started	_____
Cycle length	_____ days
Estimated fertile window	_____
Intercourse dates	_____
Positive OPK	_____
Most fertile mucus	_____
Pregnancy test / result	_____
What we learned	_____

MONTH 3

Item	Record
Period started	_____
Cycle length	_____ days
Estimated fertile window	_____
Intercourse dates	_____
Positive OPK	_____
Most fertile mucus	_____
Pregnancy test / result	_____
What we learned	_____

THE MOST IMPORTANT BOX
If pregnancy has not occurred, the point at which we will seek professional advice is: _____. A good plan includes knowing when the plan needs to change.



THE ONE-PAGE TTC CHEAT SHEET

1. Find the fertile window

Think approximately six days ending around ovulation. Do not focus only on one predicted date. Source: ASRM.

2. Start before ovulation

Sperm can remain viable for several days, while the egg has a much shorter post-ovulation fertilization period. Source: ACOG.

3. Do not assume Day 14

Ovulation is not universally on Cycle Day 14. Source: ACOG.

4. Have sex regularly

Targeted: every 1-2 days during the fertile window. Low pressure: every 2-3 days throughout the cycle. Sources: ASRM and NICE.

5. Use fertility clues if they help

Cycle history, cervical mucus, OPKs, and BBT can provide different kinds of information.

6. Forget the magic position

No intercourse position has been established as necessary for conception. Source: ASRM.

7. You do not need your legs in the air

Specific post-intercourse positions have not been proven to improve natural fertility.

8. Semen leakage does not mean failure

Visible fluid after intercourse does not tell you whether sperm have already moved into the reproductive tract.

9. Urinating does not flush sperm out of the uterus

The urethra and reproductive tract are different pathways.

10. Female orgasm is not required

Do not make orgasm another TTC performance requirement.

11. Choose lubricant thoughtfully

Some lubricants can affect sperm parameters in laboratory testing. Consider TTC or sperm-compatible products. Source: ASRM.

12. His fertility counts

Male reproductive history and semen assessment belong in fertility evaluation. Source: AUA/ASRM.

13. Prepare before pregnancy

Review folic acid, medications, smoking, drugs, alcohol, chronic conditions, and general health. Sources: CDC, ACOG, NHS.

14. Know when to get help

General ASRM guidance: under 35 - about 12 months; 35 or older - about 6 months; over 40 - more immediate evaluation may be appropriate.

FINAL CHECKLIST

[ ] Do I know my usual cycle length?

[ ] Do I understand my likely fertile window?

[ ] Are we starting intercourse before predicted ovulation?

[ ] Are we having sex regularly enough?

[ ] Have I stopped relying on Day 14 alone?

[ ] Am I using fertility signs if they are useful?

[ ] Have we stopped wasting energy on unsupported rituals?

[ ] Are we considering male fertility?

[ ] Are we doing sensible preconception preparation?

[ ] Do we know when we will seek professional evaluation?

Your Job Is to Improve the Opportunity, Not Control the Outcome

You can do everything correctly and still not become pregnant in one cycle. Human reproduction does not work like a vending machine where correct timing guarantees a result.

You cannot force an egg to be released, see fertilization happen, control every sperm parameter, correct every reproductive condition through intercourse, or command implantation.

What you can control is preparation. You can learn your cycle, identify your likely fertile window, begin intercourse before ovulation, stop wasting energy on unsupported rituals, include both partners, recognize when irregular cycles deserve medical attention, and know when it is time to seek professional help.

> **THE TRANSFORMATION**
> This is not a secret way to guarantee pregnancy. It is a practical, evidence-based way to stop guessing and give yourselves a better-informed opportunity to conceive naturally.

When your next cycle begins, start with Day 1. Find your window. Watch your signs if useful. Cover the opportunity. Stay connected to your partner. Know when to ask for help. You now have a plan. Use it.

RESEARCH AND MEDICAL REFERENCES

American Society for Reproductive Medicine (ASRM)
Optimizing Natural Fertility: A Committee Opinion. Used for fertile-window timing, intercourse frequency, fertility-awareness methods, sexual-position myths, and lubricant guidance.

American Society for Reproductive Medicine (ASRM)
Fertility Evaluation of Infertile Women: A Committee Opinion. Used for evaluation timing, ovulatory assessment, reproductive tract assessment, and age-related guidance.

American Urological Association / ASRM
Diagnosis and Treatment of Infertility in Men. Used for male fertility evaluation, semen analysis, reproductive history, and testosterone-related considerations.

American College of Obstetricians and Gynecologists (ACOG)
Trying to Get Pregnant? Here's When to Have Sex; Fertility Awareness-Based Methods; and Prepregnancy Counseling.

National Institute for Health and Care Excellence (NICE)
Fertility Problems: Assessment and Treatment, NG257. Used for current fertility guidance including regular intercourse every two to three days.

World Health Organization (WHO)
Infertility Fact Sheet. Used for infertility causes and reproductive-tract factors.

Centers for Disease Control and Prevention (CDC)
Folic Acid Guidance and Infertility FAQs.

NHS
Trying for a Baby / Medicines and Pregnancy guidance.

MEDICAL DISCLAIMER
This guide is for educational purposes. Consult a healthcare professional before making changes to your health routine. It does not replace individualized medical advice, fertility assessment, diagnosis, or treatment. No intercourse schedule, tracking method, supplement, sexual technique, fertility-awareness method, or lifestyle change can guarantee pregnancy. Seek appropriate medical care if you have symptoms, known reproductive or medical conditions, medication concerns, pregnancy loss, or difficulty conceiving.