

What Happens at the First Fertility Appointment?

A Complete Step-by-Step Guide for Couples — Medical History, Semen Analysis, Ovulation, AMH, Ultrasound, Fallopian-Tube Testing, Sexual Health, Treatment Planning and the Integrative Role of Unani Medicine

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A Message From Dr. Nizamuddin Qasmi

When a couple books their first fertility consultation, they often arrive with a mixture of:

hope,

anxiety,

embarrassment,

fear,

dozens of laboratory reports,

advice collected from friends and the internet.

One of the most common questions I hear is:

“Doctor, what will happen at our first fertility appointment?”

Some couples are frightened that the very first visit will immediately lead to:

IVF.

Others believe that only the woman will be tested.

Some women have already undergone:

repeated ultrasounds,

hormone tests,



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HSG,

several treatment cycles,

while the husband's fertility has never been evaluated.

Other couples arrive carrying extensive panels of:

AMH,

FSH,

LH,

prolactin,

thyroid hormones,

insulin,

vitamins,

immune tests,

genetic tests,

without anyone first asking a basic question:

Why has pregnancy not occurred?

My first message to couples is:

The first fertility appointment should primarily be an investigation and planning visit—not an automatic IVF appointment.

The purpose is to understand the couple's reproductive story and determine:

whether infertility is actually present,

whether either partner has an obvious risk factor,

whether ovulation appears normal,

whether the fallopian tubes may need assessment,

whether the uterus requires evaluation,

whether male fertility has been assessed,

whether sexual dysfunction is reducing the opportunity for conception,

which tests are genuinely necessary.

The World Health Organization's **first global guideline on infertility**, published on **28 November 2025**, promotes evidence-based, stepwise and people-centred fertility care,



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progressing from accurate diagnosis and simpler interventions toward treatments such as IUI or IVF only when clinically appropriate.

This principle is central to my approach at Saira Health Care:

Diagnose before treating.

What Is the Main Goal of the First Fertility Appointment?

The first visit should answer several basic questions.

First:

Is there actually an infertility problem?

Second:

Is there an obvious female factor?

Third:

Is there an obvious male factor?

Fourth:

Is intercourse occurring regularly and effectively?

Fifth:

Which investigations are necessary now?

Sixth:

Which investigations can safely be avoided?

Seventh:

What should the couple do next?

A good first appointment therefore creates:

a diagnostic roadmap.

It should not simply generate:

a large laboratory bill.

ASRM specifically recommends that infertility evaluation be conducted:

systematically,

expeditiously,



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cost-effectively,

with an initial emphasis on the **least invasive methods for detecting the most common causes of infertility.**

When Should You Book a First Fertility Appointment?

For couples without known reproductive problems, the usual guidance is based partly on the woman's age.

Woman younger than 35 years

Evaluation is generally recommended after approximately:

12 months

of regular unprotected intercourse without pregnancy.

Woman aged 35 years or older

Evaluation should generally begin after approximately:

6 months.

Woman older than 40 years

A more immediate fertility discussion and evaluation may be appropriate.

ACOG's infertility guidance, last reviewed in **May 2026**, follows this general framework.

But these timelines should never be used blindly.

Some Couples Should Not Wait 6 or 12 Months

ASRM recommends beginning fertility evaluation without unnecessary delay when a condition already exists that is associated with infertility.

Examples include:

irregular menstrual cycles,

absent periods,

cycles shorter than approximately 25 days,

known or suspected endometriosis,

previous significant PID,

previous ectopic pregnancy,



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known tubal disease,
hydrosalpinx,
known uterine abnormality,
previous chemotherapy or pelvic radiation,
known diminished ovarian reserve,
known male infertility,
previous abnormal semen analysis,
erectile dysfunction,
ejaculatory dysfunction,
vaginismus,
painful intercourse preventing regular sex.

Therefore:

the first fertility appointment may sometimes be appropriate before the formal definition of infertility has been reached.

Infertility Is a Couple's Condition

This is one of the most important principles in modern fertility medicine.

WHO defines infertility as a disease of:

the male or female reproductive system

characterized by failure to achieve pregnancy after 12 months or more of regular unprotected intercourse.

Infertility may result from:

female factors,

male factors,

combined factors,

unexplained factors.

WHO estimates that approximately:

one in six people

experience infertility during their lifetime.



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Therefore, I do not like the traditional approach in which:

the woman is investigated first for six months and the man is tested only after everything is normal.

That can waste valuable reproductive time.

Both Partners Should Ideally Be Involved From the Beginning

The AUA/ASRM male-infertility guideline recommends that:

male and female partners undergo concurrent assessment.

The initial male evaluation should include:

reproductive history,

semen analysis.

ASRM gives the same couple-based message in female infertility evaluation:

when a male partner contributes sperm, both partners should begin evaluation at the same time.

This does not mean both partners need the same number of tests.

It means:

do not ignore half of the reproductive equation.

What Happens When You First Sit Down With the Fertility Doctor?

In many cases, the most valuable part of the first appointment is not:

ultrasound,

injection,

blood test.

It is:

the history.

ACOG states that the first infertility visit usually includes:

detailed medical history,

reproductive history,

physical examination where appropriate.



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A good fertility history can immediately identify whether the likely problem involves:
ovulation,
tubes,
sperm,
sexual intercourse,
reproductive ageing.

What I Ask the Couple at the First Appointment

I usually begin with:

“How long have you actually been trying for pregnancy?”

This sounds simple, but the answer often requires clarification.

A couple may say:

“Three years.”

But when I ask more carefully:

the husband works abroad,
they lived together for only six months,
intercourse occurred infrequently.

Another couple may say:

“Only eight months.”

But the woman is:

39 years old,
has previous severe PID.

These couples should not be interpreted in the same way.

Therefore I ask about:

actual months of regular exposure to conception.

How Often Are You Having Sexual Intercourse?

This is clinically important.



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Pregnancy requires:

ovulation,

sperm,

effective intercourse during the fertile period.

If intercourse occurs:

once per month

and repeatedly outside the fertile window, the couple has a lower opportunity for conception than a couple having regular intercourse.

ASRM fertility guidance considers:

frequency of intercourse,

ovulation monitoring,

sexual dysfunction

important components of the fertility history.

Sexual History Is Part of the Fertility Consultation

Patients should not feel embarrassed if I ask:

Is penetration occurring normally?

Does the erection remain adequate until ejaculation?

Does ejaculation occur inside the vagina?

Is intercourse painful?

Is there fear of penetration?

These questions are not irrelevant or intrusive.

They may directly identify:

erectile dysfunction,

performance anxiety,

ejaculatory dysfunction,

vaginismus,

dyspareunia.



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ASRM specifically recommends assessment for:

erectile dysfunction,

ejaculatory dysfunction,

low libido

in men undergoing fertility evaluation.

If sperm is not being deposited effectively:

calculating AMH will not solve the basic problem.

Performance Anxiety During Fertility Treatment

I see this frequently.

A couple begins monitoring:

ovulation apps,

LH tests,

follicular scans.

The wife tells her husband:

“Today is the exact day—we have to have intercourse.”

Suddenly the man develops:

loss of erection,

delayed ejaculation,

inability to perform.

He may function normally during spontaneous intercourse.

This is:

fertility-related performance anxiety.

ASRM recognizes that infertility itself can increase male sexual dysfunction and emphasizes asking about it during fertility care.

In such a patient:

treating sexual anxiety may be an important fertility intervention.



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The Female Fertility History

I ask the woman detailed questions about:

age,

menstrual cycles,

previous pregnancies,

miscarriages,

ectopic pregnancies,

surgeries,

infections,

endometriosis symptoms,

previous fertility treatment.

Menstrual Cycle History

I want to know:

At what age did periods begin?

How many days apart are the periods?

Are they regular?

Are periods absent for months?

Is there excessive bleeding?

Is there bleeding between periods?

Is menstrual pain unusually severe?

Why?

Because the menstrual pattern gives valuable information about:

ovulation.

Regular Periods and Ovulation

ASRM states that when menstrual cycles are regular and generally fall between approximately:



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21–35 days,

additional testing solely to prove ovulation is often unnecessary unless other clinical concerns are present.

This means:

every regularly cycling woman does not need monthly progesterone tests simply because she has infertility.

The doctor must ask:

what question is the test trying to answer?

Irregular Periods

If cycles occur every:

40 days,

60 days,

several months,

I consider:

ovulatory dysfunction.

Possible causes include:

PCOS,

thyroid disease,

hyperprolactinaemia,

hypothalamic dysfunction,

primary ovarian insufficiency,

other endocrine conditions.

In this situation:

identifying the cause of irregular ovulation is more useful than repeatedly guessing the fertile window.

Previous Pregnancies Matter

I ask:



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Have you ever been pregnant?

This includes pregnancies ending in:

live birth,

miscarriage,

abortion,

ectopic pregnancy.

A previous pregnancy means conception occurred previously, but fertility can change later.

Difficulty conceiving after a previous pregnancy is called:

secondary infertility.

WHO recognizes both:

primary infertility,

secondary infertility.

Miscarriage History

One miscarriage is unfortunately common and does not necessarily mean infertility.

Repeated pregnancy loss is different.

The couple may become pregnant relatively easily but have difficulty:

maintaining pregnancy.

That requires a different reproductive pathway from someone who never conceives.

Therefore I ask:

how many pregnancies occurred?

at what gestational age were they lost?

were any genetic investigations performed?

Previous Ectopic Pregnancy

A previous ectopic pregnancy is important because it may indicate:

tubal disease.



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I want to know:

which tube was involved,

whether the tube was removed,

whether the opposite tube looked healthy,

whether methotrexate or surgery was used.

This can influence:

how quickly tubal assessment should be considered.

Previous PID or STI

A history of:

chlamydia,

gonorrhoea,

PID,

tubo-ovarian abscess

raises concern about possible:

fallopian-tube damage.

The woman may now have no infection at all.

Therefore, after old PID, repeatedly prescribing antibiotics is usually less useful than asking:

Are the tubes functioning?

This is where:

HSG,

HyCoSy

may become appropriate.

Endometriosis Symptoms

I ask about:

severe menstrual pain,



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chronic pelvic pain,
deep painful intercourse,
previous endometrioma,
endometriosis surgery.

Known or suspected endometriosis is a recognized reason for:

earlier fertility investigation.

Previous Uterine Surgery

Important history can include:

fibroid surgery,
hysteroscopy,
D&C,
caesarean section,
removal of polyps,
uterine-septum surgery.

Some procedures can affect:

uterine cavity,
adhesions,
pregnancy.

But a history of surgery does not automatically mean infertility.

The significance depends on:

what procedure was performed and why.

Previous Ovarian Surgery

I ask about:

ovarian-cyst surgery,
endometrioma surgery,
ovarian torsion,



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removal of part or all of an ovary.

Some ovarian surgeries can affect:

ovarian reserve.

This may influence whether:

AMH,

antral follicle count

are useful.

Chemotherapy and Radiation

Previous cancer treatment can affect:

egg supply,

sperm production,

reproductive organs.

ASRM specifically identifies:

chemotherapy,

radiation

as conditions that can justify prompt fertility assessment.

Family History

I ask whether there is a family history of:

early menopause,

infertility,

recurrent miscarriage,

genetic disease,

congenital abnormalities.

This may identify situations where:

genetic counselling

or more specific testing is appropriate.



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What I Ask the Male Partner

The male history is not simply:

“Do you have any problem?”

I ask specifically about:

previous pregnancies fathered,
childhood testicular conditions,
sexual function,
operations,
medications,
steroid use,
infections,
lifestyle.

Previous Fertility

I ask:

Have you fathered a pregnancy before?

A previous child does not guarantee current fertility.

Semen quality can change because of:

age,
varicocele,
medication,
illness,
hormonal disorders,
testicular injury.

Therefore:

secondary male infertility exists.



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Undescended Testis

A history of:

cryptorchidism

is important.

The effect on fertility depends partly on:

whether one or both testes were affected,

timing of treatment.

Men with significant cryptorchidism history may deserve:

earlier semen evaluation.

Testicular Torsion, Injury or Surgery

I ask about:

testicular torsion,

severe trauma,

hernia surgery,

hydrocele surgery,

genital surgery.

These can occasionally affect:

testicular function,

sperm transport.

Mumps Orchitis and Other Testicular Infection

Post-pubertal mumps involving the testis can occasionally affect:

sperm production.

Significant epididymitis or genital-tract infection can also become relevant.

Again:

history guides testing.



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Varicocele

Some men already know they have a varicocele.

Not every varicocele causes infertility.

I consider:

clinical examination,

semen findings,

fertility history.

Treatment is not decided merely because an ultrasound report says:

“small varicocele.”

Testosterone and Anabolic Steroids

This is extremely important.

I specifically ask:

Are you taking testosterone?

Gym injections?

Bodybuilding steroids?

Men sometimes believe testosterone will:

improve sperm.

It can do the opposite.

Exogenous androgens can suppress the hormonal signals required for sperm production.

Therefore, the AUA/ASRM guideline pays particular attention to:

medications,

exogenous steroid exposure

during male reproductive evaluation.

Medications and Supplements

Both partners should bring a list of:



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prescription medicines,
nonprescription medicines,
vitamins,
fertility supplements,
herbal medicines,
Unani medicines.

Some medications may influence:

ovulation,
prolactin,
testosterone,
spermatogenesis,
sexual function.

Do not stop important medication without medical advice.

The point is:

review it intelligently.

Smoking, Alcohol and Recreational Drugs

I ask both partners about:

tobacco,
vaping/nicotine,
alcohol,
cannabis,
recreational drugs.

This is not moral judgement.

These exposures may affect:

general health,
sexual function,
sperm,



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reproductive outcomes.

WHO's September **2026** fertility update specifically highlighted tobacco as a modifiable risk associated with:

female infertility,

adverse sperm effects,

male sexual dysfunction,

potentially poorer fertility-treatment outcomes.

Therefore:

tobacco cessation is part of fertility treatment.

Occupational Exposures

I ask about:

excessive heat,

pesticides,

solvents,

heavy metals,

radiation,

industrial chemicals.

Evidence varies by exposure.

But occupation may occasionally provide an important clue to reproductive risk.

Does the Doctor Perform a Physical Examination on the First Visit?

Sometimes.

But:

not every patient requires every physical examination at the first consultation.

ASRM specifically notes that fertility examination should be:

targeted to detect conditions relevant to reproductive potential,

and that a complete physical or gynecological examination is not mandatory for every patient presenting for infertility evaluation.



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The examination depends on:

symptoms,

history,

available previous records.

Female Examination

Where clinically indicated, examination may assess:

body weight/BMI,

signs of androgen excess,

thyroid findings,

pelvic findings,

vaginal/cervical abnormalities.

But many structural reproductive questions are better answered by:

ultrasound.

Male Examination

If male infertility is suspected—particularly if semen is abnormal—a reproductive examination may assess:

testicular size,

testicular consistency,

epididymis,

vas deferens,

varicocele,

genital abnormalities.

AUA/ASRM recommends specialist male reproductive assessment when significant semen abnormalities or presumed male-factor infertility are present.

What Tests May Be Ordered After the First Appointment?

This depends entirely on the history.



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The basic fertility evaluation should answer three broad questions:

Is ovulation occurring?

Are the female reproductive tract and fallopian tubes suitable for conception?

Is the male partner producing adequate sperm?

ASRM specifically identifies:

ovulatory status,

female reproductive structure/tubal patency,

semen evaluation

as core elements of infertility assessment.

Semen Analysis — One of the Most Important Early Tests

When a male partner contributes sperm, semen analysis should usually be performed:

early in the infertility evaluation.

AUA/ASRM recommends:

reproductive history,

one or more semen analyses

as foundational parts of male assessment.

This test is:

noninvasive,

relatively inexpensive,

highly informative.

What Does a Semen Analysis Measure?

A semen analysis typically assesses:

semen volume,

sperm concentration,

total sperm number,

motility,



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progressive motility,
morphology,
sometimes vitality,
other semen characteristics.

But it is important to understand:

semen analysis is not a simple fertile/infertile score.

AUA/ASRM emphasizes that individual semen parameters above or below reference limits do not, by themselves, perfectly predict whether a man is fertile or infertile.

The entire clinical context matters.

What If the Semen Analysis Is Abnormal?

Do not panic.

Semen values can vary between samples.

Factors such as:

fever,
recent illness,
collection problems,
abstinence period
may influence results.

A repeat sample is often appropriate when the first analysis is significantly abnormal.

AUA/ASRM also recommends additional male reproductive evaluation when one or more semen parameters are abnormal.

Does Every Man Need Hormone Tests?

No.

This is a common example of over-testing.

Male FSH, testosterone and other hormones are especially useful when there is:

azoospermia,
significant oligospermia,



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reduced libido,
erectile dysfunction,
small testes,
clinical evidence of endocrine abnormality.

AUA/ASRM does **not** recommend a full hormone panel as a universal first-line test in every infertile man.

Does Every Man Need Scrotal Ultrasound?

No.

AUA/ASRM specifically states that:

scrotal ultrasound should not routinely be performed as part of every initial male infertility evaluation.

Ultrasound is used when:

examination,
symptoms,
another clinical indication
makes it useful.

Does Every Man Need Sperm DNA Fragmentation Testing?

No.

AUA/ASRM does not recommend sperm-DNA-fragmentation analysis as part of the routine initial infertility evaluation.

It may be considered later in selected situations.

This is an important lesson:

an expensive test is not automatically a better first test.

What About Genetic Tests for the Man?

Genetic testing can become very important in men with:

azoospermia,



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severe sperm-production abnormalities,
suspected congenital obstruction,
certain reproductive histories.

Depending on the finding, tests might include:

karyotype,
Y-chromosome microdeletion testing,
CFTR testing.

But:

these are targeted tests.

They are not routinely required in every man with mild semen abnormalities.

Female Ultrasound

Transvaginal pelvic ultrasound is one of the most useful imaging tools in fertility evaluation.

It can provide information about:

uterus,
endometrium,
ovaries,
antral follicles,
ovarian cysts,
endometriomas,
fibroids.

Depending upon timing and the purpose of the scan, it may also assess:
follicular development.

Does a Normal Ultrasound Mean Fertility Is Normal?

No.

A normal ultrasound does not prove:



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fallopian tubes are open,

sperm is normal,

egg quality is normal.

Different fertility tests answer:

different questions.

One of the most common misunderstandings is:

“My ultrasound is normal, so why am I not pregnant?”

Because ultrasound assesses only:

part of the reproductive system.

What Is AMH?

AMH stands for:

Anti-Müllerian Hormone.

It is widely used as one marker of:

ovarian reserve.

It can help estimate:

expected ovarian response during fertility treatment.

But it must be interpreted correctly.

AMH Is Not an Egg-Quality Test

AMH does **not** directly tell us:

whether an individual egg is genetically normal,

whether natural conception will occur this month.

A low AMH result does not automatically mean:

pregnancy is impossible.

A high AMH does not guarantee:

excellent fertility.

ASRM specifically warns that ovarian-reserve testing is a:



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poor standalone predictor of fertility

and should be used as an adjunct in infertility evaluation rather than as a universal fertility-screening test.

What Other Ovarian-Reserve Tests May Be Used?

Depending on the clinical situation:

antral follicle count,

basal FSH,

estradiol

may also contribute.

Again:

age remains extremely important.

A younger woman with lower ovarian reserve may still have very different reproductive prospects from an older woman with the same AMH value.

Does Every Woman Need Hormone Tests?

No.

Testing should respond to the history.

Possible hormone investigations include:

TSH

when thyroid disease is relevant.

Prolactin

when there is:

amenorrhoea,

galactorrhoea,

clinical suspicion.

Androgen testing

when there are signs such as:

hirsutism,



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suspected PCOS.

Progesterone

when confirmation of ovulation is genuinely needed.

ASRM specifically does **not** recommend routine prolactin or broad endocrine testing in every infertility patient without an indication.

What About “Day-2” or “Day-3” Hormones?

Selected tests such as:

FSH,

estradiol

may be obtained in the early follicular phase when ovarian-reserve information is needed.

But a woman should not assume that a fertility consultation is incomplete unless:

every Day-2 hormone has been ordered.

Testing is individualized.

Progesterone Testing

If ovulation is uncertain, serum progesterone may sometimes be useful.

The timing should generally relate to:

the expected next menstrual period

rather than automatically being performed on:

Day 21

for every woman.

A woman with a:

35-day cycle

may ovulate later than a woman with a 28-day cycle.

Therefore:

fertility tests should follow physiology—not fixed calendar traditions.



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Checking the Fallopian Tubes

The fallopian tubes are essential for:

sperm transport,

egg pickup,

fertilization,

embryo transport.

If both tubes are significantly blocked:

natural fertilization may not occur.

Tubal assessment is therefore an important part of infertility evaluation when indicated.

HSG — Hysterosalpingography

HSG is an X-ray-based test in which contrast is introduced through the cervix to evaluate:

uterine cavity,

whether contrast passes through the fallopian tubes.

ASRM identifies HSG as a recommended method for evaluating:

tubal patency.

HyCoSy or Sonographic Tubal Testing

Ultrasound-based contrast methods can also be used to evaluate tubal patency in appropriate settings.

The choice depends on:

local expertise,

availability,

patient factors.

Does Every Woman Need HSG at the First Appointment?

No.

A woman who has:



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just started trying,

no infertility,

no tubal risk

does not need HSG merely because she visited a fertility clinic.

But when infertility is established:

tubal status often becomes an important component of evaluation.

It may deserve especially early attention when there is:

previous PID,

ectopic pregnancy,

significant pelvic surgery.

Can HSG Show Everything About the Fallopian Tubes?

No.

HSG mainly shows:

whether contrast passes.

A tube can be:

patent,

but still have:

fimbrial damage,

ciliary dysfunction,

surrounding adhesions.

Therefore:

an open tube is encouraging but is not a guarantee of perfect tubal function.

Does Every Woman Need Laparoscopy?

No.

Routine diagnostic laparoscopy is **not** part of the basic infertility assessment for every woman.



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ASRM specifically lists laparoscopy among investigations that should not be performed routinely without another indication.

It may become useful when there is strong suspicion of:

endometriosis,

pelvic adhesions,

another surgical problem.

What About Hysteroscopy?

Hysteroscopy uses a small camera to examine:

the inside of the uterus.

It can identify or treat conditions such as:

endometrial polyps,

submucosal fibroids,

uterine septum,

intrauterine adhesions.

But it is not necessary for every couple on the first day.

Ultrasound or saline sonography may first raise suspicion of a cavity abnormality.

Should Every Woman Have an Endometrial Biopsy?

No.

ASRM does not recommend routine endometrial biopsy as part of standard infertility evaluation without a specific clinical indication.

What About the Old Post-Coital Test?

Historically, doctors sometimes examined cervical mucus after intercourse to see whether sperm were present.

Routine post-coital testing is:

no longer recommended

as part of modern standard infertility evaluation.



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This is another example of fertility care becoming more:
evidence-based.

Are Immune Tests Needed?

Usually:

not during routine first-line infertility evaluation.

Large panels of:

immunologic tests,

thrombophilia tests

should not automatically be performed in every couple.

ASRM specifically advises against routine use of:

thrombophilia testing,

immunological testing

without another clinical indication.

Should Every Couple Have Chromosome Testing?

No.

Genetic testing is extremely important when indicated.

But karyotype testing is not required in every infertile couple.

It may be indicated in selected circumstances such as:

severe male infertility,

recurrent pregnancy loss,

suggestive family history.

What About Infection Tests?

Testing may be appropriate depending on:

symptoms,

STI history,



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fertility-treatment requirements,

pregnancy planning.

Important infections may include:

chlamydia,

gonorrhoea,

HIV,

syphilis,

hepatitis B,

hepatitis C.

But an indiscriminate:

“all infection panel”

is not automatically part of every basic infertility diagnosis.

Fertility Testing Should Be Stepwise

This is one of the strongest recommendations I give patients.

The evaluation should usually move from:

history → basic examination → basic reproductive tests → targeted advanced tests.

Not:

advanced tests first.

WHO's 2025 global guideline similarly advocates progressive, evidence-based management—from fertility-promotion advice and simpler interventions toward more complex treatments when the clinical findings justify them.

What Happens After the Initial Tests Are Ordered?

The first appointment may end with a plan such as:

Woman

pelvic ultrasound,

ovarian-reserve testing,

HSG,



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selected endocrine tests.

Man

semen analysis.

Then:

return with results.

The next consultation brings these pieces together.

The Diagnosis Is Usually Built From the Couple's Combined Results

The fertility doctor may eventually identify:

ovulatory infertility,

tubal-factor infertility,

endometriosis-associated infertility,

uterine factor,

diminished ovarian reserve,

male-factor infertility,

sexual dysfunction,

combined infertility,

unexplained infertility.

Treatment depends upon:

the diagnosis.

What Is Unexplained Infertility?

Sometimes:

ovulation appears normal,

fallopian tubes appear patent,

semen analysis is reasonably acceptable,

yet pregnancy does not occur.

This is often called:



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unexplained infertility.

The term does not mean:

“There is absolutely nothing wrong.”

It means:

standard investigations have not identified a specific cause.

WHO's 2025 infertility guideline specifically includes treatment pathways for:

unexplained infertility.

Does the First Appointment Mean IVF Is Necessary?

No.

This misconception causes considerable unnecessary fear.

Depending upon the diagnosis, treatment may involve:

improving intercourse timing,

treatment of sexual dysfunction,

lifestyle modification,

ovulation induction,

selected medical treatment,

selected surgery,

IUI,

IVF,

ICSI.

WHO's current fertility framework encourages moving progressively from simpler strategies toward more complex treatment according to:

diagnosis,

patient preferences,

treatment response.

Therefore:

IVF is one tool—not the definition of fertility care.



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Natural Conception Advice May Be the Treatment

Suppose a young couple has:

normal semen,

regular ovulation,

no tubal risk,

only a short duration of trying.

Their fertility consultation may conclude with:

reassurance + appropriate fertile-window intercourse.

No injections.

No IVF.

No surgery.

That is still:

proper fertility care.

Ovulation Induction

If the woman has:

anovulation,

treatment may focus on helping ovulation occur.

The exact medicine depends on the cause.

For example:

PCOS,

hypothalamic dysfunction,

hyperprolactinaemia

require different management.

One universal “egg-forming medicine” is not appropriate for every woman.

Tubal Disease



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If infertility is caused by:
significant tubal blockage,
hydrosalpinx,
treatment becomes different.

Depending on:
age,
severity,
location of disease,
ovarian reserve,
semen quality,
options may include:
reproductive surgery,
IVF.

WHO's 2025 infertility guideline includes dedicated recommendations for treatment of:
tubal-factor infertility.

Male-Factor Infertility

A male abnormality may require:
repeat semen analysis,
reproductive-urological examination,
hormonal tests,
genetic evaluation,
targeted treatment.

Some conditions are:
correctable.

Others may require:
IUI,
IVF/ICSI,



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surgical sperm retrieval.

The purpose of early male assessment is partly to avoid putting the woman through:

unnecessary invasive treatment

when the major fertility factor is actually male.

AUA/ASRM specifically emphasizes this point.

Erectile Dysfunction at the First Fertility Appointment

If erection is the main obstacle to conception, fertility care should not ignore it.

I want to know whether erectile dysfunction is:

persistent,

situational,

specifically occurring on fertile days,

related to diabetes,

associated with low libido,

related to performance anxiety.

Appropriate sexual-medicine treatment may allow:

completely natural conception.

That can be far more rational than immediately moving to ART.

Ejaculatory Dysfunction

Men with:

retrograde ejaculation,

anejaculation,

severe delayed ejaculation

require a specific approach.

Depending upon the cause, management may include:

medical treatment,

sexual therapy,



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sperm retrieval.

Again:

diagnosis comes first.

Vaginismus and Painful Intercourse

A woman may have normal:

AMH,

ultrasound,

hormones.

But if penetration is impossible because of:

vaginismus,

pregnancy opportunity remains reduced.

Likewise:

severe dyspareunia

can reduce intercourse frequency.

At Saira Health Care, because our clinical work involves:

Sexual Disorders & Infertility,

I consider this an essential part of the fertility assessment.

Fertility Is Not Only Laboratory Medicine

The couple may arrive expecting that the doctor will look only at:

numbers,

scans.

But fertility is also affected by:

sexual function,

relationship stress,

anxiety,

timing,



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age,

general health.

WHO's 2025 infertility guideline specifically recognizes the significant:

psychological,

social,

financial

burden of infertility and calls for access to psychosocial support.

The Emotional Side of the First Appointment

Many couples arrive carrying:

guilt,

fear,

social pressure.

A woman may think:

“It must be my fault.”

The man may fear:

“What if my sperm are abnormal?”

The family may already be asking:

“When are you giving us good news?”

Good fertility care should not increase this pressure.

The first visit should provide:

clarity.

Not blame.

What Should You Bring to the First Fertility Appointment?

I recommend bringing:

previous fertility reports,

semen analyses,



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ultrasound reports,
HSG reports,
hormone results,
operative records,
miscarriage or ectopic-pregnancy records,
previous IVF/IUI reports,
current medication list.

For the woman, also note:

first day of recent menstrual periods,
usual cycle length.

For the man:

details of previous genital/testicular surgery,
testosterone or steroid use.

This can avoid:

unnecessary repeat testing.

Should Both Partners Attend the Appointment?

Whenever practical:

yes.

It improves:

history taking,
communication,
shared understanding.

It also sends an important message:

infertility belongs to the couple.

Not:

“the woman has come for treatment.”



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Can the First Consultation Be by Video?

Some parts can be performed very effectively through:

video consultation,

detailed history review,

interpretation of existing reports,

planning investigations.

But physical examination, ultrasound, semen testing or procedures obviously require:

in-person services when indicated.

A first teleconsultation can nevertheless be very useful for:

organizing the work-up,

avoiding unnecessary investigations.

What Should You Ask the Fertility Doctor?

Useful questions include:

What do you think are the main possible causes in our case?

Which tests do we actually need?

Does the male partner need semen analysis now?

Do we need tubal testing?

Does AMH change management?

Are we still reasonable candidates for natural conception?

Should we consider IUI?

Is IVF actually necessary?

How does age affect our timeline?

Which treatment has the best evidence for our diagnosis?

This creates:

shared decision-making.

Questions You Should Be Cautious About



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Be careful if fertility treatment is presented as:

guaranteed pregnancy.

No ethical fertility treatment can guarantee:

natural conception,

IVF success,

live birth.

Probability depends on:

age,

diagnosis,

egg quality,

sperm,

uterus,

embryo factors.

Responsible treatment should discuss:

realistic expectations.

Red Flags for Over-Testing at the First Appointment

You may reasonably ask why a test is being ordered if every patient automatically receives:

sperm-DNA fragmentation,

immune panels,

thrombophilia panels,

laparoscopy,

endometrial biopsy,

every reproductive hormone,

repeated ultrasounds

before basic couple evaluation is complete.

ASRM explicitly recommends against routine use of several of these investigations in the initial work-up without an appropriate indication.



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Red Flags for Under-Testing

The opposite problem is also common.

A couple has been trying for:

three years,

and receives only:

fertility tablets,

supplements

without:

semen analysis,

tubal evaluation,

diagnosis.

This can waste:

reproductive time.

Fertility care should be:

neither excessive nor incomplete.

The Unani Perspective on the First Fertility Consultation

In Unani medicine, infertility has traditionally been discussed under:

‘Uqr

with attention to the reproductive condition of:

both partners.

The traditional approach may consider:

Mizaj or constitutional temperament,

reproductive function,

menstrual health,

sexual wellbeing,

nutrition,



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digestion,

sleep,

physical condition.

These concepts can provide valuable context for:

whole-person fertility care.

But modern reproductive diagnostics allow us to answer questions that classical physicians could not answer objectively.

Today we can evaluate:

sperm concentration,

motility,

ovarian reserve,

follicular development,

fallopian-tube patency,

uterine anatomy,

genetics.

I see this as:

a strength for modern integrative Unani practice.

How Unani Medicine Can Be Useful in Fertility Care

Unani medicine may have a useful supportive role in selected patients by addressing:

nutritional wellbeing,

digestive health,

metabolic balance,

menstrual health in selected functional disorders,

sexual wellbeing,

general health.

In men, individualized management may be useful in selected cases involving:

general reproductive health,



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sexual health,

some semen abnormalities.

But treatment should always be matched to:

the actual diagnosis.

Unani Research in Male Infertility

Unani clinical literature includes studies evaluating traditional formulations in:

oligospermia.

For example, a CCRUM-hosted comparative analysis involving 126 men across earlier studies reported changes in several semen parameters with different Unani formulations.

This research is relevant and supports continued scientific investigation.

But important limitations remain.

Much of the evidence is:

older,

small,

heterogeneous,

focused on semen parameters,

not designed around live-birth outcomes.

Therefore it cannot justify the claim that:

one Unani medicine cures every cause of male infertility.

Improving Sperm Count Is Not the Same as Treating Every Male-Factor Diagnosis

Suppose a man has:

mild idiopathic oligospermia.

Supportive treatment may be considered.

But a man with:

complete AZFa Y-chromosome deletion

has a fundamentally different condition.



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A man with:

obstructive azoospermia

has another.

Therefore:

the first fertility appointment must establish the diagnosis before choosing a traditional or modern treatment.

Unani Medicine and Female Infertility

Traditional Unani care may contribute supportively in selected women with:

nutritional issues,

metabolic problems,

menstrual irregularity,

sexual-health concerns.

But one should never say:

every female infertility problem is a “uterine weakness.”

Modern infertility may arise from:

anovulation,

endometriosis,

bilateral tubal blockage,

intrauterine adhesions,

diminished ovarian reserve,

age-related egg decline,

genetic problems.

These require different treatment pathways.

Can Unani Medicine Open Every Blocked Fallopian Tube?

There is insufficient high-quality evidence to claim that Unani medicine can reliably reopen:

established dense fibrotic tubal obstruction.



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If a tube is blocked because of:

scar tissue,

hydrosalpinx,

severe structural damage,

the patient may require:

surgery,

IVF.

A responsible Unani physician should distinguish:

functional disorders

from:

irreversible structural disease.

Can Unani Medicine Restore Ovarian Reserve?

There is no established treatment—Unani or conventional—that has been proven to:

regenerate a woman's primordial ovarian follicle pool to a younger biological state.

Supportive treatment may improve:

general health,

nutritional status,

metabolic factors.

But it should not be marketed as:

permanent ovarian rejuvenation.

Can Unani Medicine Help Sexual Dysfunction Affecting Fertility?

This is an area where integrative management may be particularly useful.

If conception is being limited by:

performance anxiety,

low sexual confidence,

erectile problems,



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general weakness,

lifestyle factors,

the patient may benefit from:

sexual counselling,

medical treatment when indicated,

individualized Unani supportive care.

Because Saira Health Care focuses on both:

Sexual Disorders & Infertility,

this connection is especially relevant to our clinical approach.

Unani Treatment Should Not Delay Time-Sensitive Fertility Care

This principle is extremely important.

Suppose the woman is:

40 years old

and has significantly reduced ovarian reserve.

Spending two years trying multiple empirical tonics may substantially reduce the remaining reproductive opportunity.

Similarly, a man with severe azoospermia should not spend years without:

genetic,

hormonal,

reproductive-urological assessment.

My preferred approach is:

investigate first → integrate treatment second.

Special Fertility Assessment by Dr. Nizamuddin Qasmi

When a couple consults me at Saira Health Care, I do not begin by asking:

“Which fertility package would you like?”

I begin with the couple's story.



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I want to identify whether their problem is most likely related to:

timing,

ovulation,

tubes,

uterus,

sperm,

sexual function,

reproductive age,

or:

a combination of factors.

Only then do we decide what needs testing.

Stage One — Understand the Couple

We review:

ages,

duration of infertility,

primary or secondary infertility,

menstrual cycles,

previous pregnancies,

sexual frequency,

medical/surgical history.

Stage Two — Look for Immediate Clues

Examples include:

Woman

irregular cycles,

endometriosis,

PID,



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ectopic pregnancy,
ovarian surgery.

Man

testicular history,
varicocele,
steroid use,
previous abnormal semen.

Couple

erectile dysfunction,
ejaculation difficulty,
painful intercourse.

Stage Three — Basic Investigations

Depending upon the case:

Male

Semen analysis.

Female

Possible:
ultrasound,
ovarian-reserve assessment,
targeted hormones.

Couple

selected infection/genetic testing where indicated.

Stage Four — Tubal/Uterine Evaluation

If appropriate:

HSG,
HyCoSy,

saline sonography,
hysteroscopy in selected cases.

Stage Five — Establish the Most Likely Diagnosis

The objective is to categorize the main problem as:

ovulatory,
tubal,
uterine,
ovarian reserve,
male factor,
sexual factor,
unexplained,
combined.

Stage Six — Choose the Least Unnecessarily Invasive Effective Treatment

WHO's current guideline supports progressively advancing fertility management based on:

clinical findings,
patient preferences,
response to simpler strategies.

Treatment might therefore begin with:

natural-conception counselling,
sexual-disorder treatment,
ovulation management,
selected Unani supportive care.

Or it may require:

IUI,
surgery,



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IVF,

ICSI

when the diagnosis justifies them.

Patient Example — Young Couple Trying for Only Four Months

Woman:

27,

regular cycles.

Man:

healthy.

No risk factors.

They usually do not need:

AMH,

HSG,

laparoscopy,

sperm-DNA fragmentation.

The first appointment may simply provide:

reassurance,

fertile-window counselling,

preconception health advice.

That is good fertility medicine.

Patient Example — Woman Age 36, Trying for Seven Months

Now the approach changes.

ACOG recommends fertility evaluation after approximately:

six months

in women older than 35.

We should begin appropriate:



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female evaluation,
male semen analysis.

Patient Example — Woman With Periods Every 60 Days

This woman may have:

irregular ovulation.

Instead of immediately performing every fertility test, the early focus may be:

endocrine/ovulatory evaluation,

pelvic ultrasound,

semen analysis of the partner.

Patient Example — Previous Severe PID

Her cycles may be completely normal.

But ovulation is not the main concern.

Her history raises a different question:

Are the fallopian tubes patent and functional?

Tubal evaluation may deserve priority.

Patient Example — Husband Has Not Been Tested After Four Years of Infertility

I would generally not continue evaluating the woman alone.

A semen analysis is:

essential.

Male and female evaluation should proceed concurrently.

Patient Example — Husband Cannot Maintain an Erection on Fertile Days

His semen may be completely normal.

The reproductive barrier may be:

sexual performance.



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Appropriate treatment may restore effective intercourse and allow:
natural conception.

Patient Example — Azoospermia

If the semen analysis shows:

no sperm,

we do not simply give a sperm tonic.

We need to determine:

Why?

Possible categories include:

obstructive azoospermia,

nonobstructive sperm-production failure,

hormonal causes.

The evaluation may then include:

examination,

FSH/testosterone,

genetics,

other targeted tests.

Patient Example — Very Low AMH

A woman arrives in tears because her AMH is low.

My first job is:

interpretation.

I explain that AMH gives information primarily about:

ovarian reserve,

expected ovarian response.

It does not by itself tell us:

“You can never become pregnant.”



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Her:

age,

cycle pattern,

antral follicle count,

reproductive history,

tubes,

partner semen

all matter.

Patient Example — Normal AMH but No Pregnancy

High or normal AMH does not rule out:

tubal blockage,

endometriosis,

male factor,

uterine disease.

Therefore:

never interpret fertility from one laboratory number.

Patient Example — Couple Asking for IVF Immediately

Sometimes IVF is clearly indicated.

But sometimes:

intercourse is poorly timed,

ovulation is irregular but treatable,

sexual dysfunction exists,

basic evaluation is incomplete.

A good fertility consultation should determine whether IVF is:

necessary,

rather than simply:



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available.

Frequently Asked Questions

What happens at the first fertility appointment?

Usually:

detailed reproductive history,

medical history,

sexual history,

review of previous reports,

targeted examination where necessary,

plan for appropriate investigations.

ACOG describes detailed history and appropriate examination as central components of the first visit.

Should husband and wife both attend?

Ideally yes.

Male and female fertility should be evaluated in parallel where applicable.

Will I have an ultrasound on the first day?

Possibly.

It depends on:

cycle timing,

symptoms,

existing reports,

clinical need.

Will all tests be done on the first day?

Usually no.



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Some tests need particular:

cycle days,

preparation,

appointments.

Do I need to come fasting?

Not for every fertility visit.

Only selected metabolic or other blood investigations require fasting.

Follow the clinic's instructions.

Does the first appointment mean IVF?

No.

Fertility evaluation is:

diagnosis first.

Treatment follows the diagnosis.

What is usually the first test for the husband?

Semen analysis.

It is a foundational male fertility test.

Should the husband wait until all female tests are normal?

No.

Concurrent evaluation is recommended.

Do all men need testosterone and FSH testing?

No.

Hormonal testing is targeted to particular histories and semen abnormalities.



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Does every man need scrotal ultrasound?

No.

AUA/ASRM does not recommend routine scrotal ultrasound in the initial evaluation of every infertile man.

Does every man need sperm-DNA fragmentation testing?

No.

It is not recommended as a universal initial test.

Does every woman need AMH?

No.

AMH should be used in an appropriate infertility context rather than as a universal fertility screening test.

Does AMH measure egg quality?

No.

Age is much more closely related to:

oocyte quality.

AMH primarily reflects:

ovarian reserve/expected response.

Does low AMH mean natural pregnancy is impossible?

No.

Does a high AMH guarantee pregnancy?

No.

Does every woman need HSG?

No.

But tubal-patency evaluation is important in established infertility when clinically appropriate.

ASRM recommends HSG or sonographic methods for this purpose.

Does HSG prove the tube works perfectly?

No.

It primarily demonstrates:

passage/patency.

It cannot measure every aspect of tubal function.

Does every woman need laparoscopy?

No.

Routine diagnostic laparoscopy is not recommended without a clinical indication.

Does every woman need prolactin?

No.

It is used when there is a clinical indication.

Does every regularly cycling woman need progesterone to prove ovulation?

Usually not.

ASRM states that menstrual history is often adequate when cycles are regularly 21–35 days.

Do I need immune testing?

Not routinely.

Do I need thrombophilia tests?

Not during routine infertility evaluation without another reason.



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Is post-coital testing still needed?

Not routinely.

Should we test for infections?

When:

history,

symptoms,

fertility-treatment protocol

indicates it.

What if I previously had PID?

Tell your fertility physician.

It may increase concern about:

tubal factor.

What if I had ectopic pregnancy?

Bring all records.

The history may affect:

tubal assessment,

future pregnancy monitoring.

What if my periods are very irregular?

Tell the doctor.

This may indicate:

ovulatory dysfunction

and can guide targeted hormonal assessment.

What if my periods are regular?



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Ovulation is more likely, but regular periods do not guarantee:

open tubes,

normal semen,

normal uterine anatomy.

Should sexual problems be mentioned?

Absolutely.

ASRM recommends evaluating sexual dysfunction during fertility care.

Can erectile dysfunction cause infertility?

It can reduce natural-conception opportunity if effective intercourse cannot occur.

Can premature ejaculation cause infertility?

Usually not if ejaculation occurs:

inside the vagina.

If ejaculation consistently occurs before penetration, conception may be affected.

Can delayed ejaculation affect fertility?

Yes, particularly if ejaculation cannot occur intravaginally.

Can vaginismus affect fertility?

Yes.

If penetration is not possible, vaginismus itself becomes a fertility-related barrier.

Can painful intercourse affect fertility?

Yes, particularly if intercourse becomes:

infrequent,

impossible.



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The underlying cause should be investigated.

Can performance anxiety affect conception?

Yes.

Fertility pressure can worsen:

erectile function,

ejaculation,

sexual frequency.

Should we bring old fertility reports?

Yes.

Bring:

scans,

semen tests,

HSG,

hormones,

surgery records,

previous treatment records.

Do we need to repeat every old test?

No.

A clinician should review whether previous results remain:

useful,

sufficiently recent,

technically adequate.

How many visits are needed before a diagnosis?

This varies.



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ACOG notes that infertility evaluation can often be completed within:

a few menstrual cycles.

Many basic questions can be answered much sooner.

What is the most important first test?

There is no single test for every couple.

The most important starting point is:

detailed couple-based history.

Semen analysis is a fundamental early test for the male partner when infertility evaluation is indicated.

Can Unani medicine be started at the first appointment?

It may be incorporated where appropriate.

But I prefer:

diagnosis-led treatment.

Is there one Unani medicine for infertility?

No.

Infertility has many causes.

A man with oligospermia does not need the same treatment as a man with:
obstructive azoospermia.

A woman with PCOS does not need the same treatment as a woman with:
bilateral tubal blockage.

Has Unani medicine been studied for male infertility?

Yes.

Unani literature includes clinical studies in oligospermia, including research evaluating changes in semen parameters.

The evidence remains limited compared with large modern fertility trials.



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Can Unani medicine increase sperm count?

Selected small studies report improvements in some semen parameters.

Whether a treatment is likely to help depends on:

the cause.

Structural and genetic infertility require specific evaluation.

Can Unani treatment guarantee pregnancy?

No responsible treatment can guarantee pregnancy.

Can Unani medicine replace IVF?

Not when IVF is medically indicated because of conditions such as:

severe bilateral tubal damage,

selected severe male factors.

Can Unani treatment help avoid unnecessary IVF?

Potentially, in the sense that:

accurate diagnosis and appropriate treatment of correctable problems

may allow some couples to conceive without IVF.

But whether IVF is necessary depends on:

diagnosis,

age,

duration of infertility.

A Message From Dr. Nizamuddin Qasmi to Women

Please do not come to a fertility clinic believing:

“The problem must be inside my body.”

Infertility belongs to the:

couple.

Your evaluation may include:

menstrual history,

ultrasound,

tubal testing.

But your partner's reproductive health matters equally.

You should not undergo years of treatment while the male partner remains untested.

A Message to Men

Please do not think:

“My wife has not conceived, so she needs treatment.”

Come to the fertility appointment.

Provide your:

medical history,

reproductive history,

sexual history.

When fertility evaluation is appropriate:

have the semen analysis.

A semen analysis is not a test of:

masculinity,

sexual power.

It is simply:

a reproductive laboratory test.

A Message to Couples With Sexual Problems

If intercourse is difficult:

please say so.

Do not feel embarrassed.



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Sometimes the most useful information in the entire fertility appointment is:

“Doctor, I lose my erection whenever we try during ovulation.”

or:

“Penetration is too painful.”

or:

“I cannot ejaculate inside the vagina.”

These statements can immediately reveal an important reason conception is not occurring.

A Message About Unani Medicine

As a physician trained in Unani medicine, I believe fertility care benefits from looking beyond a laboratory report.

I consider:

general wellbeing,

Mizaj,

nutritional health,

digestion,

sleep,

metabolic health,

sexual function.

These areas can contribute meaningfully to:

reproductive health.

But good Unani medicine should not ignore what modern reproductive diagnostics can show us.

If a semen analysis identifies:

azoospermia,

we should investigate azoospermia.

If HSG demonstrates:

bilateral tubal disease,



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we should address tubal-factor infertility.

If the woman has:

severe age-related ovarian decline,

we should discuss reproductive time honestly.

The best model is:

traditional whole-person care + modern diagnosis + evidence-based fertility planning.

Saira Health Care's Contribution to Sexual Disorders & Infertility

At **Saira Health Care**, infertility assessment is particularly comprehensive because sexual function and fertility are considered together.

Our clinical work may involve:

male infertility,

female infertility,

abnormal semen,

azoospermia,

oligospermia,

sexual dysfunction,

erectile dysfunction,

performance anxiety,

ejaculation disorders,

painful intercourse,

reproductive infections,

fertility planning.

Many couples do not fit neatly into only:

“fertility”

or:

“sexual medicine.”

For example:



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A man may have normal sperm but severe:
performance anxiety.

A woman may ovulate normally but have:
vaginismus.

A couple may be labelled infertile when the true problem is:
ineffective intercourse.

This is why the first fertility appointment should explore:
the entire reproductive relationship.

Dr. Nizamuddin Qasmi's Specialized Clinical Approach

As a well-qualified physician with a **specialized clinical focus in Sexual Disorders & Infertility**, my approach at the first appointment is based on:

listening first,

testing selectively,

treating the diagnosed cause.

My training includes:

BUMS — Hamdard University, Delhi

MD

CGO

Certificate in Infertility — MGBIMS, Delhi

Certificate in Urology — London, UK

Masters in Male Infertility — MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health — ISRH, UNFPA

I use this combined background to assess fertility not merely as a laboratory problem, but as an interaction of:

reproductive physiology,

sexual function,

male health,

female health,

couple health.



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Current Medical Understanding — 2026 Update

Fertility care has changed significantly in recent years.

WHO published the world's first comprehensive global infertility guideline on:

28 November 2025.

It contains evidence-based recommendations addressing:

prevention,

diagnosis,

ovulatory infertility,

tubal disease,

uterine-cavity disorders,

male-factor infertility,

unexplained infertility.

WHO's framework specifically promotes progression from:

fertility education and simpler management

toward:

IUI and IVF

according to:

clinical findings,

response,

patient preferences.

This supports a central principle:

a fertility clinic should not be an automatic IVF clinic.

ACOG's infertility information, last reviewed in:

May 2026,

continues to emphasize that the first fertility visit should involve:

detailed history,

appropriate examination,



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targeted tests,

and confirms that evaluation involves:

both partners.

ASRM recommends a:

systematic, expeditious and cost-effective

investigation emphasizing the least invasive methods that identify common fertility problems.

For women, a standard evaluation generally addresses:

ovulation + reproductive anatomy/tubal patency.

For men:

reproductive history + semen analysis.

The AUA/ASRM male-infertility guideline, amended in **2024**, further emphasizes the need to evaluate the male partner because a proper male diagnosis can sometimes prevent the female partner from undergoing:

unnecessary,

expensive,

invasive

treatment.

Modern guidance also increasingly discourages routine use of advanced investigations without a reason.

Examples include:

routine sperm-DNA fragmentation,

routine scrotal ultrasound,

routine laparoscopy,

routine immune testing,

routine thrombophilia panels,

routine endometrial biopsy.

This represents a fundamental shift from:

“test everything”



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toward:

“test what will change management.”

WHO's 2025 guidance also recognizes the substantial emotional and social burden of infertility and recommends access to:

psychosocial support

throughout fertility care.

This is equally important because infertility is not only:

ovaries,

sperm,

tubes.

It affects:

relationships,

sexual confidence,

mental wellbeing.

Conclusion

The first fertility appointment is primarily about understanding why pregnancy has not occurred and designing a logical, couple-based investigation plan.

It should begin with:

a detailed history.

For the woman this commonly includes:

age,

cycle pattern,

previous pregnancies,

miscarriages,

ectopic pregnancy,

PID,

endometriosis,

surgery,



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previous fertility treatment.

For the man:

reproductive history,

testicular history,

medication use,

testosterone/steroid use,

sexual function,

previous fertility.

For the couple:

duration of trying,

intercourse frequency,

fertile-window timing,

sexual problems.

The basic fertility evaluation should answer three major questions:

Is ovulation occurring?

Are the female reproductive tract and fallopian tubes suitable?

Is male fertility adequate?

ASRM supports evaluation of:

ovulatory status,

reproductive anatomy and tubal patency,

semen analysis

as core elements of infertility assessment.

The male partner should usually be assessed:

at the same time.

AUA/ASRM recommends:

male reproductive history,

semen analysis

from the beginning of infertility evaluation.



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Depending upon the case, the woman may need:

pelvic ultrasound,

AMH/antral follicle count,

selected hormones,

HSG or HyCoSy.

But:

not every woman needs every fertility test.

AMH is not a universal fertility score.

HSG is not needed in every healthy woman simply planning pregnancy.

Laparoscopy is not a standard first test.

Similarly, every man does not automatically need:

extensive hormones,

sperm-DNA fragmentation,

scrotal ultrasound,

genetic studies.

These are:

targeted investigations.

The results are then used to determine whether the couple's main fertility issue is:

ovulatory,

tubal,

uterine,

ovarian reserve,

male factor,

sexual dysfunction,

unexplained,

combined.

Treatment may then range from:

natural-conception counselling



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to:

ovulation treatment,
sexual-disorder treatment,
selected surgery,
IUI,
IVF,
ICSI.

WHO's 2025 global guideline supports this:

progressive, diagnosis-led treatment pathway.

From the **Unani perspective**, fertility has traditionally been understood in a broader whole-person context involving:

Mizaj,
nutrition,
digestion,
menstrual health,
reproductive function,
sexual health.

Unani clinical literature includes research in conditions such as:

oligospermia,

with some studies reporting improvements in semen parameters after selected traditional formulations.

This makes Unani medicine a potentially valuable component of:

carefully selected integrative fertility care.

But current evidence does not justify treating:

every infertile man,
every infertile woman
with one universal Unani fertility medicine.

And Unani medicine should not be used to delay appropriate diagnosis of:

azoospermia,



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severe genetic male infertility,
bilateral tubal blockage,
hydrosalpinx,
significant ovarian ageing,
another structural infertility factor.

At **Saira Health Care**, my approach is therefore:

**listen to the couple → assess both partners → identify sexual-function barriers →
order the least unnecessary tests → evaluate semen early → assess ovulation and
female reproductive anatomy → investigate tubes where needed → establish the
diagnosis → integrate responsible Unani supportive care where appropriate →
choose the simplest effective fertility treatment.**

My most important message to couples before their first fertility appointment is:

Do not be frightened by the consultation.

The first visit does not mean:

“You need IVF.”

It means:

“Let us understand your reproductive situation properly.”

Once the cause is understood, fertility treatment becomes:

clearer, more rational and more personalized.

About the Author

Dr. Nizamuddin Qasmi

**Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility**

Qualifications & Professional Training

BUMS — Hamdard University, Delhi

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Certificate in Infertility — MGBIMS, Delhi

Certificate in Urology — London, UK



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Integrated Sexual and Reproductive Health — ISRH, UNFPA

Dr. Nizamuddin Qasmi is a well-qualified physician with a **specialized clinical focus on Sexual Disorders & Infertility** at Saira Health Care.

His approach combines assessment of:

male infertility,
female infertility,
abnormal semen,
ovulation disorders,
reproductive infections,
erectile dysfunction,
ejaculation disorders,
performance anxiety,
painful intercourse,
other sexual problems affecting conception.

Depending upon the couple's individual situation, evaluation may include:

reproductive and sexual history,
semen analysis,
menstrual and ovulatory assessment,
ovarian-reserve evaluation when clinically appropriate,
pelvic ultrasound,
tubal evaluation,
selected hormonal investigation,
male reproductive assessment,
infection or genetic investigation when indicated.

Where clinically suitable, individualized Unani principles may be integrated to support:

nutrition,
digestion,
metabolic health,



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reproductive wellbeing,
sexual health,
general physical health.

The aim at **Saira Health Care** is not simply:

“Give fertility medicine.”

The objective is to determine:

Why has pregnancy not occurred?

Is the problem male, female, sexual, combined or unexplained?

Which tests are really needed?

Which tests can be avoided?

Can natural conception still reasonably occur?

Is time-sensitive fertility treatment required?

and:

How can evidence-based reproductive medicine and responsible Unani supportive care be integrated for this particular couple?

Medical Disclaimer

This article is intended for professional education and general public awareness. It does not replace an individualized fertility evaluation by an appropriately qualified physician, gynecologist, reproductive-medicine specialist, male-reproductive specialist/urologist or other appropriate healthcare professional.

The investigations required at a first fertility appointment vary according to:

age,
duration of infertility,
reproductive history,
menstrual pattern,
previous pregnancy,
sexual function,
previous infections,



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surgery,

male reproductive history.

Not every woman requires:

AMH,

every reproductive hormone,

HSG,

hysteroscopy,

laparoscopy

at the first visit.

Not every man requires:

hormonal testing,

sperm-DNA fragmentation,

scrotal ultrasound,

genetic testing

during initial evaluation.

A semen analysis is nevertheless a foundational early investigation when male fertility is being evaluated, and male and female partners should generally be assessed concurrently when applicable.

Ovarian-reserve tests such as AMH should not be interpreted as direct yes/no tests of natural fertility or egg quality.

Sexual problems including erectile dysfunction, ejaculatory dysfunction, vaginismus and painful intercourse should be disclosed because they can directly reduce opportunities for conception.

Unani medicine may be used as supportive integrative treatment in selected patients, but current evidence is insufficient to use Unani treatment as a replacement for appropriate investigation or established treatment of serious structural, genetic or severe reproductive disorders.

No responsible fertility treatment—including Unani treatment, medication, IUI, IVF or ICSI—can guarantee pregnancy or live birth.



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