Reproductive Health and Infertility Practice Test (Sample)

Study Guide

Everything you need from our exam experts!

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- **Practice answering questions under realistic conditions,**
- **Improve accuracy and speed,**
- **Review explanations to strengthen weak areas, and**
- **Approach the exam with greater confidence.**

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here’s how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don’t just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There’s no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

1. How do sexually transmitted infections impact fertility?

A. It always resolves without affecting fertility.

B. It can cause tubal factor infertility and chronic pelvic pain.

C. It enhances fertility.

D. It only affects male fertility.

2. Which genetic consideration is used to improve implantation success and reduce miscarriage risk in infertility treatments?

A. Maternal blood typing

B. Sperm motility alone

C. Embryo screening for aneuploidy

D. Donor selection criteria

3. What are the indications for preimplantation genetic testing (PGT)?

A. Known genetic disorders, high aneuploidy risk, or chromosomal rearrangements

B. Universal use for all IVF cycles

C. Guarantees a healthy baby

D. Replaces genetic counseling

4. Which category accounts for 10% of infertility cases?

A. Female factors

B. Male factors

C. Unexplained

D. Primary infertility

5. What is a consequence of inadequate production of FSH and LH in males?

A. It can lead to increased sperm production

B. It can lead to inadequate sperm production

C. It has no impact on fertility

D. It enhances testosterone levels

6. What is the primary purpose of fertility preservation for cancer patients undergoing gonadotoxic therapy?

A. To enhance chemotherapy effects

B. To preserve future fertility before gonadotoxic therapy via oocyte/embryo cryopreservation or ovarian tissue cryopreservation

C. To reduce cancer risk

D. To speed up treatment

7. Which is a limitation of PGT?

A. It guarantees a healthy baby

B. Mosaicism can lead to false results

C. It is available everywhere at no cost

D. It requires no specialized lab facilities

8. Which statement accurately describes minimal stimulation IVF?

A. It uses high-dose gonadotropins.

B. It reduces cost and risk and may yield similar outcomes in selected patients.

C. It guarantees more eggs.

D. It is no longer used.

9. Which of the following is a key consideration in donor gamete programs?

A. Parental rights and legal parentage must be defined.

B. Donor anonymity is never allowed.

C. Only medical screening is required.

D. Embryo disposition is unrelated to donor programs.

10. Which of the following is a contraindication to combined oral contraceptives (COCs)?

A. Amenorrhea not due to pregnancy

B. Vitamin deficiency

C. Age under 17

D. Pregnancy

Answers

1. B
2. C
3. A
4. C
5. B
6. B
7. B
8. B
9. A
10. D

Explanations

1. How do sexually transmitted infections impact fertility?

A. It always resolves without affecting fertility.

B. It can cause tubal factor infertility and chronic pelvic pain.

C. It enhances fertility.

D. It only affects male fertility.

Infections transmitted sexually often inflame the reproductive tract, and when they reach the upper genital tract they can cause pelvic inflammatory disease. This inflammation can scar and block the fallopian tubes, which are essential for the egg and sperm to meet. That scarring is what we call tubal factor infertility, a common way STIs lead to difficulty conceiving. The ongoing inflammatory process and scar tissue can also produce chronic pelvic pain that lasts even after the infection is treated. While early treatment can prevent some damage, for many people the effects on fertility are long-lasting if the tubes are affected. This concept explains why tubal factor infertility and chronic pelvic pain are the typical fertility-related consequences of sexually transmitted infections.

2. Which genetic consideration is used to improve implantation success and reduce miscarriage risk in infertility treatments?

A. Maternal blood typing

B. Sperm motility alone

C. Embryo screening for aneuploidy

D. Donor selection criteria

Embryo genetic screening for aneuploidy targets the chromosomal makeup of the embryo itself. Many implantation failures and miscarriages in infertility treatments are caused by embryos that have the wrong number of chromosomes (aneuploidy). By testing embryos before transfer and selecting those with the normal number of chromosomes (euploid), clinicians place embryos with the highest likelihood of proper development back into the uterus. This approach directly improves the chance of successful implantation and reduces the risk of miscarriage compared with transferring embryos without regard to chromosomal status. Other options don't specifically address embryo chromosome balance: maternal blood type concerns immune or compatibility factors but not embryonic viability; focusing on sperm motility improves fertilization chances but not the chromosomal integrity of the embryo; donor selection criteria can influence genetics indirectly but does not systematically reduce the risk of aneuploidy-related miscarriage in the usual infertility treatment context.

3. What are the indications for preimplantation genetic testing (PGT)?

A. Known genetic disorders, high aneuploidy risk, or chromosomal rearrangements

B. Universal use for all IVF cycles

C. Guarantees a healthy baby

D. Replaces genetic counseling

Indications for preimplantation genetic testing focus on preventing transmission of known genetic risks to the embryo. It is most appropriate when there is a known genetic problem that could be passed on to a child, or when the likelihood of abnormal chromosome numbers is higher and could lead to miscarriage or a affected baby. Specifically, this includes scenarios where one or both parents carry a known single-gene disorder, situations with a high risk of aneuploidy (such as advanced maternal age or a history of miscarriages due to chromosomal abnormalities), and when a parent has a chromosomal rearrangement like a balanced translocation that could produce affected embryos. Breaking it down, PGT is done in conjunction with IVF to test embryos for these issues before transfer. PGT has different forms: PGT for single-gene disorders, PGT for aneuploidy, and PGT for structural rearrangements. The goal is to select embryos that are free of the specific genetic problem or chromosomal abnormality, reducing the chance of affected offspring and pregnancy loss. However, PGT does not guarantee a healthy baby. Mosaicism can complicate results, tests have limitations based on what and how they screen, and not all conditions are detectable with current testing. It's also not used universally for every IVF cycle; the decision depends on the individual risk profile. Genetic counseling remains essential to interpret test results, discuss options, and guide family planning decisions.

4. Which category accounts for 10% of infertility cases?

A. Female factors

B. Male factors

C. Unexplained

D. Primary infertility

Unexplained infertility is identified when a full fertility workup does not reveal a cause despite normal evaluations. After testing semen quality, confirming ovulation, and checking for tubal patency and uterine anatomy, if no problem is found, the infertility is labeled unexplained. This category accounts for about 10% of infertility cases, reflecting the limitations of standard tests and the possibility of subtle issues not detected by routine assessments (such as mild endometriosis, subclinical ovulatory disturbances, or nuanced sperm function problems). The other categories point to identifiable issues: female factors involve ovulation or tubal/uterine problems; male factors involve abnormal semen or related issues; primary infertility simply means the couple has never conceived, rather than indicating a share of cases.

5. What is a consequence of inadequate production of FSH and LH in males?

A. It can lead to increased sperm production

B. It can lead to inadequate sperm production

C. It has no impact on fertility

D. It enhances testosterone levels

FSH and LH from the pituitary are essential for male fertility. LH stimulates Leydig cells to produce testosterone, which supports sperm development, while FSH acts on Sertoli cells to nurture germ cells and promote their maturation and spermiation. When production of these hormones is inadequate, Sertoli cell support and intratesticular testosterone both fall, impairing spermatogenesis. The result is reduced sperm production and potential infertility. This wouldn't boost sperm count or testosterone levels; rather, it would lower them and impair fertility.

6. What is the primary purpose of fertility preservation for cancer patients undergoing gonadotoxic therapy?

A. To enhance chemotherapy effects

B. To preserve future fertility before gonadotoxic therapy via oocyte/embryo cryopreservation or ovarian tissue cryopreservation

C. To reduce cancer risk

D. To speed up treatment

Preserving future reproductive potential before gonadotoxic cancer therapy is the main goal. Treatments like certain chemotherapies and radiation can permanently damage the ovaries and cause infertility, so the aim is to secure a chance to have biological children later by freezing eggs or embryos (oocyte/embryo cryopreservation) or freezing ovarian tissue (ovarian tissue cryopreservation). These options are chosen based on age, time available before treatment, and cancer type; egg/embryo freezing requires ovarian stimulation and a short delay, while ovarian tissue freezing can be done with little to no delay and is usable in prepubertal patients or when time is limited, though it has different success rates and considerations. This purpose is distinct from trying to enhance chemotherapy effects, reduce cancer risk, or speed up treatment.

7. Which is a limitation of PGT?

A. It guarantees a healthy baby

B. Mosaicism can lead to false results

C. It is available everywhere at no cost

D. It requires no specialized lab facilities

Preimplantation Genetic Testing aims to screen embryos for chromosomal abnormalities or specific gene mutations before IVF transfer. A key limitation is mosaicism: the embryo can contain a mix of normal and abnormal cells. Since only a few cells are biopsied, those cells may not reflect the genetic status of the entire embryo. This can lead to false results, such as labeling an embryo as normal when abnormal cells exist, or discarding an embryo that could develop normally. Mosaicism varies between embryos and can complicate interpretation, so PGT cannot guarantee a healthy baby. Other statements don't fit as limitations: PGT does not guarantee a healthy baby, it is not universally available at no cost, and it requires specialized lab facilities and trained personnel to perform the biopsy and genetic analysis.

8. Which statement accurately describes minimal stimulation IVF?

A. It uses high-dose gonadotropins.

B. It reduces cost and risk and may yield similar outcomes in selected patients.

C. It guarantees more eggs.

D. It is no longer used.

Minimal stimulation IVF uses milder ovarian stimulation regimens, often with oral agents like letrozole or clomiphene and only low-dose injectable gonadotropins, to recruit fewer follicles. The aim is to lower cost, reduce the need for intensive monitoring, and minimize the risk of ovarian hyperstimulation syndrome, while still achieving similar pregnancy outcomes in carefully selected patients. That balance—less burden and risk with the possibility of comparable results in the right candidates—best describes minimal stimulation IVF. It does not focus on producing more eggs, is still in use today, and differs from high-dose stimulation used in conventional IVF.

9. Which of the following is a key consideration in donor gamete programs?

A. Parental rights and legal parentage must be defined.

B. Donor anonymity is never allowed.

C. Only medical screening is required.

D. Embryo disposition is unrelated to donor programs.

In donor gamete programs, establishing clear parental rights and legal parentage is essential. This ensures there is a definite legal framework for who is recognized as the parent, who is responsible for child support and decision-making, and how inheritance and custody issues would be handled, protecting the child's welfare under varying national and local laws. Policies on donor anonymity vary by jurisdiction and program; some protect donor identity, others allow it to be disclosed to offspring at adulthood, so anonymity is not universally mandated or prohibited. Medical screening matters, but it's not the only consideration—the process also includes psychosocial assessment, informed consent, confidentiality, long-term disclosure policies, and regulatory compliance. Embryo disposition is also a real consideration, as plans for stored or surplus embryos must align with donor and recipient agreements and legal/ethical guidelines, linking directly to how donor programs are structured.

10. Which of the following is a contraindication to combined oral contraceptives (COCs)?

A. Amenorrhea not due to pregnancy

B. Vitamin deficiency

C. Age under 17

D. Pregnancy

A key idea here is that any condition that makes using estrogen-containing contraception unsafe or unnecessary is a contraindication. Pregnancy is an absolute contraindication because giving hormonal pills to someone who is already pregnant offers no contraceptive benefit and could pose risks to the developing fetus. When pregnancy is present, contraception should not be started or continued. The other scenarios don't automatically rule out combined oral contraceptives. Amenorrhea not due to pregnancy doesn't by itself ban COCs; many people with irregular or absent menses use COCs to regulate cycles once pregnancy is excluded and the underlying cause is considered. A vitamin deficiency isn't a direct safety issue with COCs, so it isn't a contraindication. Age under 17 isn't an automatic restriction either; adolescents can use COCs with appropriate medical evaluation and choice of formulation.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

https://reproductivehealthinfertility.examzify.com

We wish you the very best on your exam journey. You've got this!