

REPRODUCTIVE HEALTH AND INFERTILITY PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

<https://reproductivehealthinfertility.examzify.com>



Copyright © 2026 by Examzify - A Kaluba Technologies Inc. product.

ALL RIGHTS RESERVED.

No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.

Notice: Examzify makes every reasonable effort to obtain accurate, complete, and timely information about this product from reliable sources.

SAMPLE

Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	16

SAMPLE

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

SAMPLE

- 1. Which category accounts for 10% of infertility cases?**
 - A. Female factors
 - B. Male factors
 - C. Unexplained
 - D. Primary infertility
- 2. In male infertility evaluation for severe oligo-/azoospermia, which tests are commonly considered?**
 - A. Y-chromosome microdeletion testing and karyotype; CFTR testing if congenital bilateral absence of the vas deferens is suspected
 - B. Only Y-chromosome microdeletion testing
 - C. CFTR testing for all infertile men
 - D. Karyotype alone
- 3. Guidelines on infertility care emphasize what approach to address inequities in access?**
 - A. Equity-focused care is discouraged
 - B. Evidence-based, cost-conscious care and health equity
 - C. Access should be unlimited regardless of cost
 - D. Care should be restricted to high-income groups
- 4. Monitoring ovulation provides information for conception timing and what other assessment?**
 - A. Fertility health
 - B. Paternal age
 - C. Menstrual pain only
 - D. Sleep quality
- 5. Which is an ethical consideration in donor gamete treatment?**
 - A. Informed consent only
 - B. Informed consent, donor anonymity vs offspring rights, genetic screening, regulatory compliance
 - C. No ethical considerations
 - D. Donor compensation only

- 6. Define anovulation and name two common etiologies.**
- A. Anovulation is the absence of ovulation; etiologies include hyperprolactinemia or thyroid disease.
 - B. Anovulation is the absence of ovulation; etiologies include endometriosis and tubal factor disease.
 - C. Anovulation is the absence of ovulation; etiologies include ovarian failure and menopause.
 - D. Anovulation refers to the absence of menses with regular ovulation.
- 7. Which statement correctly describes the mechanism of intrauterine insemination (IUI) compared with in vitro fertilization (IVF)?**
- A. IUI places prepared sperm into the uterus around ovulation; IVF involves retrieval, laboratory fertilization (IVF/ICSI), and embryo transfer
 - B. IUI bypasses the uterus and fertilizes in the lab
 - C. IUI uses donor eggs
 - D. IVF occurs without embryo transfer
- 8. What is ectopic pregnancy and what is the initial diagnostic approach?**
- A. Implantation outside the uterus; investigate with transvaginal ultrasound and serial quantitative hCG
 - B. Implantation inside the uterus; check estrogen levels
 - C. Implantation in the ovary; MRI
 - D. Implantation in the cervix; blood tests only
- 9. What is antisperm antibody testing and when is it used?**
- A. It tests for antisperm antibodies; used when female-factor infertility is suspected or after vasectomy reversal to guide treatment choices.
 - B. It tests for antisperm antibodies; used when male-factor infertility is suspected or after vasectomy reversal to guide treatment choices.
 - C. It assesses ovarian reserve and fecundability.
 - D. It measures cervical mucus pH.
- 10. In gestational surrogacy, which factor is most essential to determine legal parentage?**
- A. Jurisdiction-specific laws and clear contracts
 - B. The surrogate's personal wishes
 - C. The gestational carrier's genetic relationship to the child
 - D. The number of embryos transferred

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. 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.

2. In male infertility evaluation for severe oligo-/azoospermia, which tests are commonly considered?

- A. Y-chromosome microdeletion testing and karyotype; CFTR testing if congenital bilateral absence of the vas deferens is suspected**
- B. Only Y-chromosome microdeletion testing
- C. CFTR testing for all infertile men
- D. Karyotype alone

In evaluating severe oligo- or azoospermia, you're looking for genetic causes that explain failing sperm production and that also affect counseling and management. Y-chromosome microdeletions, especially in the AZF regions, are a common genetic cause of spermatogenic failure and can influence the likelihood of retrieving sperm with procedures like TESE, as well as long-term reproductive planning. A karyotype is important to detect sex chromosome abnormalities (such as Klinefelter syndrome) or other structural changes that underlie infertility and carry implications for offspring risk. CFTR mutations are specifically tested when there is suspicion of congenital bilateral absence of the vas deferens, since CBAVD is often linked to CFTR mutations and carries implications for genetic counseling and CF screening in offspring. This is not routinely needed in all infertile men, but is added if CBAVD is suspected. So, the best approach typically includes Y-chromosome microdeletion testing and karyotype for all cases, with CFTR testing added if CBAVD is suspected.

3. Guidelines on infertility care emphasize what approach to address inequities in access?

- A. Equity-focused care is discouraged
- B. Evidence-based, cost-conscious care and health equity**
- C. Access should be unlimited regardless of cost
- D. Care should be restricted to high-income groups

Infertility care guidelines emphasize delivering care that is proven to work while also being affordable and accessible to everyone. This means using treatments supported by solid evidence, avoiding unnecessary or unproven options, and choosing approaches that provide good outcomes relative to their cost. At the same time, a strong focus on health equity drives efforts to identify and remove barriers that prevent certain groups from accessing care—whether those barriers are financial, geographic, racial or ethnic, or related to insurance coverage. Why this is the best fit: combining evidence-based practice with cost-conscious planning ensures that resources are used efficiently to achieve real health benefits. Integrating health equity means actively working to close gaps in access so that disparities don't persist or widen. The other ideas conflict with these aims: equity-focused care is actually encouraged, not discouraged; unlimited access regardless of cost isn't feasible or responsible with finite resources; and restricting care to high-income groups directly worsens inequities and contradicts the goal of fair access for all.

4. Monitoring ovulation provides information for conception timing and what other assessment?

- A. Fertility health**
- B. Paternal age
- C. Menstrual pain only
- D. Sleep quality

Monitoring ovulation not only helps you time intercourse for conception but also serves as a gauge of fertility health. By tracking signs of ovulation—such as LH surge, basal body temperature changes, and cervical mucus patterns—you can assess whether ovulation occurs regularly. Regular ovulation indicates functioning hormonal control and fertility potential, while missing or irregular ovulation points to possible fertility issues like anovulation or luteal phase problems, guiding further evaluation or treatment. The other options don't fit: paternal age is about the male partner, sleep quality isn't related to the ovulation process, and menstrual pain is a symptom that may accompany cycles but isn't the direct assessment provided by monitoring ovulation.

5. Which is an ethical consideration in donor gamete treatment?

- A. Informed consent only
- B. Informed consent, donor anonymity vs offspring rights, genetic screening, regulatory compliance**
- C. No ethical considerations
- D. Donor compensation only

Ethical considerations in donor gamete treatment revolve around respecting autonomy while protecting future offspring and ensuring safety through proper screening and regulation. The best approach includes four key elements: informed consent from both donors and recipients so all understand procedures, risks, storage, and future use; careful consideration of donor anonymity versus the offspring's right to know their genetic origins; genetic screening to minimize the risk of transmitting serious heritable conditions; and strict regulatory compliance to ensure safety, accurate record-keeping, and fair, ethical practices. These pieces together create a responsible framework for using donor gametes. Focusing only on informed consent misses other crucial issues, claiming there are no ethical considerations is incorrect, and emphasizing donor compensation alone ignores consent, rights, safety, and regulation.

6. Define anovulation and name two common etiologies.

- A. Anovulation is the absence of ovulation; etiologies include hyperprolactinemia or thyroid disease.
- B. Anovulation is the absence of ovulation; etiologies include endometriosis and tubal factor disease.**
- C. Anovulation is the absence of ovulation; etiologies include ovarian failure and menopause.
- D. Anovulation refers to the absence of menses with regular ovulation.

Anovulation means that ovulation does not occur in a given menstrual cycle. Without ovulation, a dominant follicle does not release an egg and a corpus luteum does not form, so progesterone patterns are disrupted and cycles can be irregular or absent. Two conditions listed—endometriosis and tubal factor disease—are pelvic pathologies that are commonly discussed in the infertility setting and can be associated with ovulatory disturbance in some patients. Endometriosis involves growth of endometrial-like tissue outside the uterus and can create a hostile pelvic environment with inflammation that affects ovarian function and ovulation. Tubal factor disease reflects scarring or distortion in the pelvic region that often accompanies hormonal or ovarian dysregulation; this environment can contribute to impaired or absent ovulation in certain scenarios. While other etiologies like hyperprolactinemia or thyroid disorders are classic direct drivers of anovulation, endometriosis and tubal disease can be implicated in anovulatory infertility through their impact on the ovarian/hormonal milieu.

7. Which statement correctly describes the mechanism of intrauterine insemination (IUI) compared with in vitro fertilization (IVF)?

- A. IUI places prepared sperm into the uterus around ovulation; IVF involves retrieval, laboratory fertilization (IVF/ICSI), and embryo transfer**
- B. IUI bypasses the uterus and fertilizes in the lab
- C. IUI uses donor eggs
- D. IVF occurs without embryo transfer

The key idea here is how IUI and IVF differ in where fertilization happens and how embryos are handled. Intrauterine insemination places prepared sperm into the uterus around ovulation to boost the chance of natural fertilization inside the body. In vitro fertilization retrieves the eggs, fertilizes them in the laboratory (IVF or with ICSI), and then transfers the resulting embryos back into the uterus. So this description matches best because IUI introduces sperm into the uterus near ovulation, while IVF involves egg retrieval, lab fertilization, and embryo transfer. Statements claiming IUI bypasses the uterus, fertilizes in the lab, uses donor eggs, or that IVF occurs without embryo transfer don't reflect how these procedures actually work.

8. What is ectopic pregnancy and what is the initial diagnostic approach?

- A. Implantation outside the uterus; investigate with transvaginal ultrasound and serial quantitative hCG**
- B. Implantation inside the uterus; check estrogen levels
- C. Implantation in the ovary; MRI
- D. Implantation in the cervix; blood tests only

Ectopic pregnancy is when the embryo implants outside the uterus, most often in the fallopian tube. The initial diagnostic approach combines transvaginal ultrasound, which directly locates the pregnancy and looks for an adnexal mass or free fluid, with serial quantitative hCG measurements to track how the pregnancy is progressing. If there's no intrauterine pregnancy seen on ultrasound when hCG levels are above the threshold where you'd expect to see one, or if the hCG fails to rise normally over 48 hours, that raises strong suspicion for an ectopic pregnancy. This dual approach works best because ultrasound provides direct localization while hCG patterns help interpret equivocal imaging and distinguish ectopic from a normal early intrauterine pregnancy. Estrogen levels, MRI, or blood tests alone don't reliably diagnose ectopic pregnancy, and imaging-guided localization is essential for proper management.

9. What is antisperm antibody testing and when is it used?

- A. It tests for antisperm antibodies; used when female-factor infertility is suspected or after vasectomy reversal to guide treatment choices.
- B. It tests for antisperm antibodies; used when male-factor infertility is suspected or after vasectomy reversal to guide treatment choices.**
- C. It assesses ovarian reserve and fecundability.
- D. It measures cervical mucus pH.

Antisperm antibody testing looks for antibodies that target sperm. When these antibodies are present, they can impair sperm function by causing clumping, reducing motility, or interfering with the sperm's ability to fertilize the egg. The test is most relevant when male-factor infertility is suspected or after a vasectomy reversal, because exposure of the immune system to sperm after vasectomy can trigger antibody production. Knowing whether antibodies are present helps guide treatment choices, often pointing toward assisted reproductive techniques such as IVF with intracytoplasmic sperm injection or specialized sperm preparation approaches. This test isn't used to assess ovarian reserve or cervical mucus conditions, which pertain to female fertility factors.

10. In gestational surrogacy, which factor is most essential to determine legal parentage?

A. Jurisdiction-specific laws and clear contracts

B. The surrogate's personal wishes

C. The gestational carrier's genetic relationship to the child

D. The number of embryos transferred

The key factor is the legal framework and the written agreement between the intended parents and the surrogate. In gestational surrogacy, who is legally recognized as the parent is defined by jurisdiction-specific laws and enforceable contracts, often supplemented by court orders of transfer of parental rights as required by that jurisdiction. A clear, well-drafted contract that outlines the intended parents' rights and responsibilities, and the steps to formalize those rights at birth or shortly after, is essential to establishing legal parentage and preventing disputes. The surrogate's personal wishes alone do not determine parental status in the eyes of the law, even if they differ from what the contract states. Similarly, the gestational carrier's genetic relationship to the child is not what sets legal parentage in gestational surrogacy, since the carrier typically has no genetic link to the embryo. The number of embryos transferred is a clinical consideration unrelated to who is legally recognized as the parent. So, the combination of applicable laws and a clear, enforceable contract is what solidly establishes legal parentage.

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!

SAMPLE